



NATIONAL INSTITUTE  
FOR HEALTH AND WELFARE

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ESHMS 2014 Organizing Committee (ed.)

DISCUSSION PAPER

# The 15<sup>th</sup> Biennial Conference of the European Society for Health and Medical Sociology (ESHMS)

28 – 30 August 2014

University of Helsinki, Finland

Health and Welfare Challenges in Europe: East, West, North and South

**DISCUSSION PAPER 28/2014**

Authors: Maija Kaivonurmi, Laura Kestilä, Tomi Mäki-Opas, Sakari Karvonen  
Editors: ESHMS 2014 Organizing Committee

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## Foreword

### Welcome address by ESHMS president

Dear colleagues,

I am delighted to welcome you to the 15th Biennial Conference of the European Society for Health and Medical Sociology, organized by National Institute for Health and Welfare of Finland, the Department of Public Health and the Department of Social Research of the University of Helsinki, and the Finnish Society for Social Medicine in collaboration with the ESHMS.

With a record number of participants from all over Europe and abroad we hope to have an inspiring exchange of ideas on Health and Welfare Challenges in all regions of Europe. The European political and institutional project is contested and various visions about how the future of Europe should look like abound. In the wake of the financial crisis, the economic crisis reverberates through all regions of Europe. It challenges both markets and governments to produce wealth and to redistribute it. We just started to see the first empirical studies that map out the consequences for population health and welfare. I hope to hear thought-provoking presentations and discussions that encourage scientific curiosity about these and related issues the coming three days.

The local organizing team chaired by Professor Sakari Karvonen went through great lengths to provide us with the best sociology-conference-in-the-capital-of-Finland experience ever. The ESHMS gladly took the opportunity to have its 15<sup>th</sup> conference in Finland two years ago and our expectations have not been disappointed. We enjoyed an excellent collaboration with the local organizing team the past year and hope to continue this in the coming years.

To stimulate young researchers to surprise us with their high quality research, the ESHMS will award a best paper and a best poster prize. Also, I encourage all presenters to submit their high quality papers, presented at the present conference, for publication in a special issue entirely devoted to the present conference of Social Theory & Health, the journal our society is affiliated with, entirely devoted to the present conference.

Helsinki is a young city previously known under its Swedish name *Helsingfors*, which means the Helsing rapids. I do not expect the present conference to guide European health and medical sociology through dangerous rapids towards a new future that would be a burden too heavy to carry. What I do hope is that the coming conference is an exciting scientific and social experience that will stir the water of our health sociological imagination.

Enjoy the conference and thank you for your participation,

Piet Bracke  
President ESHMS  
Department of Sociology, Ghent University

## Welcome address by the SLY

Dear Participant,

As a chair-person of the Finnish Society for Social Medicine, a co-organizer of this conference with the National Institute for Health and Welfare, I would like to warmly welcome all of you to participate in the 15th Biennial Conference of the European Society for Health and Medical Sociology.

The Finnish Society for Social Medicine is an interdisciplinary society that has around 500 members with different occupational and scientific backgrounds, aiming to promote research and education within social medicine and related areas as well as influence health policies. Society has also many active sections including Behavioural Medicine, Finnish Drug Utilisation Research Group, Reproductive Health, Health Care, Mental Health, Health Sociology, and Food Research. Furthermore, the society publishes the Finnish Journal of Social Medicine since 1963. In addition, it is an active member of several international associations such as the World Federation of the Public Health Associations (WFPHA), European Public Health Association (EUPHA), and the Nordic Societies of Social Medicine and Public Health. More information and contact details are available online: [www.socialmedicine.fi/english](http://www.socialmedicine.fi/english).

As the Society for Social Medicine, also this Conference is bringing together researchers from various scientific areas, and providing opportunities to enjoy both the rich scientific programme and social events. The scientific programme comprises three renowned key note presentations, eight parallel sessions with a number of organized symposia, and 13 different streams providing excellent opportunities to discuss on up-to-date sociological and comparative research on the topical health and welfare challenges that Europe is facing from East to West, North and South.

In addition to the diverse scientific programme, social events act as a forum for further discussions and meetings with colleagues in unique locations. First, the get-together is held at the University of Helsinki main building. The University of Helsinki is the oldest University in Finland, and has located in Helsinki since 1829, however, it was founded in Turku, in 1640, when Finland was still part of the Swedish Realm. Second, the reception will take place at the beautiful City Hall, which has a long, intriguing history of social events and culture, as it was originally designed as a hotel, opened in 1833, and functioned as a hotel for 80 years. It was an exceptionally large hotel at that time, and hosted many premieres, for example the first Finnish opera in 1852. During the World War I, a hospital for Russian marines was located in the building. Third, a conference dinner will be enjoyed in the old Cable Factory. As the name implies, the place was a cable manufacturer from 1943 until 1987. The building is currently owned by the City of Helsinki, and in addition to providing a centre for organizing e.g. different exhibitions and events, many galleries and three museums are located in the building: Finnish Museum of Photography, Hotel and Restaurant Museum and Theatre Museum.

Finally, once again, welcome to Helsinki and the 15th Biennial Conference of the European Society for Health and Medical Sociology. Enjoy the full programme and the fascinating capital of Finland!

Tea Lallukka

Chair-person of the Finnish Society for Social Medicine

## Welcome address by the Conference chair

Dear Participant,

It is with great pleasure that I want to welcome you to the 15th Biennial Conference of the European Society for Health and Medical Sociology in Helsinki. As local organizers we are convinced that the conference provides you with a unique opportunity to share views, engage in thought-provoking discussions and dwell into focused analyses highlighting the key health and welfare challenges that our societies are facing.

The local organizing committee consists of nine members representing all four main organizers: National Institute for Health and Welfare of Finland, the Department of Public Health and the Department of Social Research of the University of Helsinki, and the Finnish Society for Social Medicine. During the preparations we have also had a supportive collaboration with the ESHMS, the outcome of which is hopefully a successful conference.

We are proud of providing this opportunity for you to get acquainted with the facilities of the main building of University of Helsinki and the City of Helsinki as a location. Founded in 1640, the University of Helsinki is an international academic community of 40,000 students and staff members. The City Centre Campus extends around the historic centre of Helsinki. The main building lies next to the Senate Square with all its richness of both academic tradition and history. The Empire-style building designed by C. L. Engel and constructed in 1832 faces the Imperial Senate thus representing the idea that the university should be an integral part of the state and the city.

The city of Helsinki dates back to 1550 but it is only with the beginning of the construction of the Suomenlinna Maritime Fortress off the coast of Helsinki in 1748 to counter the growing threat from Russia that the city received more emphasis. The massive project brought additional wealth, inhabitants and merchants to the town. Particularly for those visiting Helsinki for the first time, this unique UNESCO World Heritage Site with seven small rocky islands is a place definitely worth exploring.

The status of Helsinki was raised to capital of the autonomous Grand Duchy of Finland in 1812, three years after Russia had conquered Finland. A monumental Empire-style city plan was drawn up to reflect the power of Russia and the Tsar. Finland became independent in 1917, and Helsinki assumed the demanding new role of capital of the young republic. City planning was characterised by Classicism and Functionalism that still give Helsinki its distinctive architectural flavour.

Today, Helsinki is the Capital of Finland and the centre of the Helsinki Metropolitan Area, a functional urban region of about 1.4 million inhabitants and 751,000 jobs. In its strategy, Helsinki aims to decrease health and wellbeing inequality among the citizens of the city. One of the means to achieve this is health impact assessments that are used in the City's decision-making, with the aim of reducing health inequality.

For your own health sociological observations and experiences, Helsinki will make all the difference. We sincerely hope that you do enjoy the conference and your stay.

Sakari Karvonen  
Chair of Local Organizing Committee  
National Institute for Health and Welfare, THL

## Committees

### ESHMS Executive Committee

Piet Bracke, Chair	Department of Sociology, Ghent University (Belgium)
Ofra Anson	Faculty of Health Sciences, the Ben-Gurion University of the Negev
Sara Arber	Centre for Research on Ageing and Gender (CRAG) at University of Surrey
Rudolf Forster	Ludwig Boltzmann Institut Health Promotion Research, University of Vienna
Claudine Burton-Jeangros	Department of Sociology, the University of Geneva
Terje Andreas Eikemo	Department of Public Health, Erasmus Medical Center Rotterdam
Jon Ivar Elstad	Department of Sociology and Human Geography, University of Oslo
Antonio Francesco Maturro	Faculty of Political Sciences II, Università di Bologna
Zofia Slonska	Department of Cardiovascular Diseases, the Cardinal Stefan Wyszyński Institute of Cardiology, Warsaw, Poland

### Local Organizing Committee

Sakari Karvonen, Chair	Department of Social and Health Policy and Economics, National Institute for Health and Welfare, THL
Anu Katainen	Department of Social Sciences, University of Helsinki
Laura Kestilä	Department of Social and Health Policy and Economics, National Institute for Health and Welfare, THL
Eero Lahelma	Hjelt Institute, University of Helsinki
Tomi Mäki-Opas	Department of Health, Functional Capacity and Welfare, National Institute for Health and Welfare, THL
Merja Paimensaari	Department of Communications, National Institute for Health and Welfare, THL
Ossi Rahkonen	Hjelt Institute, University of Helsinki
Ullamaija Seppälä	Department of Social Sciences, University of Helsinki
Maija Kaivonurmi, Secretary	Department of Social and Health Policy and Economics, National Institute for Health and Welfare, THL

### Scientific Committee

Piet Bracke	Chair of the European Society for Health and Medical Sociology
Jonathan Gabe	President of RC15, Sociology of Health, International Sociological Association
Ema Hresanova	Chair of RN16, Sociology of Health and Illness, European Sociological Association
Eero Lahelma	Professor of Medical Sociology, Department of Public Health, Hjelt Institute, University of Helsinki
Eva Roos	Chair of the Finnish Society for Social Medicine
Marja Vaarama	Assistant Director General, Division of Welfare and Health Policies, National Institute for Health and Welfare, THL

## Scientific programme

WEDNESDAY, AUGUST 27TH			THURSDAY, AUGUST 28TH		
09.30-16.00	Pre-conference	Room 10	8.00	Registration	Lobby
			9.00-9.30	Opening Ceremony	Small Hall
			9.30-10.30	<b>Keynote 1: Professor Ted Schrecker "Neo Liberal Epidemics: How politics makes you sick?"</b>	Small Hall
10.00-12.00	Global Health Sociology Meeting	Room 7	10.30-11.00	Coffee break	Lobby
			11.00-12.20	<b>Parallel sessions I</b>	
			1A	Health policy and services I	Room 5
			1B	Mental health I	Room 13
			1C	Smoking I	Room 10
			1D	Inequalities in self-rated health	Room 8
			1E	Disease careers I	Room 7
			1F	Professions I	Room 12
			12.20-13.30	LUNCH BREAK	
			13.30-15.00	<b>Parallel sessions II</b>	
15.00-18.30	Registration	Lobby	2A	Health care I: (pre-organized)	Room 5
			2B	Mental health II	Room 13
			2C	Smoking II (pre-organized)	Room 10
			2D	Gender and health I	Room 8
			2E	Disease careers II	Room 7
			2F	Work and well-being I (pre-organized)	Room 12
			15.00-15.30	Coffee break	Lobby
			15.30-17.00	<b>Parallel sessions III</b>	
			3A	Health care II (pre-organized)	Room 5
			3B	Mental health III	Room 13
16.00-18.00	SLY: Terveystieteiden jaos (Society for Social Medicine in Finland: Section of Health Sociology)	Room 7	3C	Health policy and services II	Room 10
			3D	Gender and health II	Room 8
			3E	Disease careers III	Room 7
17.00-18.00	Executive Committee meeting	Room 10	3F	Work and well-being II	Room 12
			17.15-18.15	General Assembly ESHMS	Small Hall
18.00-20.00	GET-TOGETHER UNIVERSITY OF HELSINKI		18.30-20.00	CITY OF HELSINKI RECEPTION CITY HALL	

FRIDAY, AUGUST 29TH			SATURDAY, AUGUST 30TH		
8.00	Registration	Lobby	8.00	Registration	Lobby
8.30-10.00	<b>Parallel sessions IV</b>		9.30-10.15	<b>Keynote 3: Docent Sirpa Wrede "How marketisation policies challenge professionalism of care in Western Europe: Subservient past, subservient future for the care workforce?"</b>	Small Hall
	4A	Recession and health in Europe I (pre-organized) Room 5	10.30-12.00	<b>Parallel sessions VIII</b>	
	4B	Health care III: use of health care Small Hall		8A	Mortality II Room 5
	4C	Physical activity I (pre-organized) Room 8		8B	Professions II: nursing Room 13
	4D	Undoing psycho-patologisation (pre-organized) Room 13		8C	Health and aging II Room 8
	4E	Health policy and services III Room 12		8D	Gender and health IV Room 10
	4F	Young people I: inequalities and life-course Room 10		8E	Nutrition and weight Room 12
	4G	Gender and health III Room 7		8F	Methods Room 7
10.00-10.20	Coffee break Lobby		12.00-12.30	Coffee break Lobby	
10.20-11.50	<b>Parallel sessions V</b>				
	5A	Recession and health in Europe II (pre-organized) Room 5			
	5B	Informal caregiving I (pre-organized) Room 7			
	5C	Physical activity II (pre-organized) Room 8			
	5D	Work and well-being III Room 13			
	5E	Health policy and services IV (pre-organized) Room 12			
	5F	Young people II: inequalities and life-course Room 10			
11.50-13.00	LUNCH BREAK		12.30-13.00	Closing session, awards Small Hall	
13.00-14.00	<b>Keynote 2: Professor Carme Borrell "Health inequalities in Southern Europe in a period of economic crisis"</b>				
		Small Hall			
14.00-15.00	<b>POSTER SESSION AND COFFEE</b>				
15.00-16.20	<b>Parallel sessions VI</b>				
	6A	Recession and health in Europe III (pre-organized) Room 5			
	6B	Informal caregiving II (pre-organized) Room 7			
	6C	Health and ageing I Room 8			
	6D	Health and immigrants I Room 13			
	6E	Health promotion and services I Room 12			
	6F	Mortality I Room 10			
16.30-18.00	<b>Parallel sessions VII</b>				
	7A	Comparative research in health sociology and social epidemiology (pre-organized) Room 5			
	7B	Informal caregiving III Room 7			
	7C	Life-style Room 8			
	7D	Health and immigrants II Room 13			
	7E	Health promotion and services II Room 12			
	7F	Work and well-being IV Room 10			
19.30-23.00	<b>CONFERENCE DINNER, The Old Cable Factory</b>				

#### STREAMS:

Health policy and services
Mental health
Health behaviour and lifestyle
Disease careers
Health care and caregiving
Gender and health
Work and well-being
Recession and health
Young people
Health and ageing
Health and immigrants
Health promotion and services
Mortality

Figure 1. Scientific programme.

**University of Helsinki, Main building, Fabianinkatu 33**

<b>Rooms (salit) = NEW building</b>
<b>2nd floor</b>
Aula / Lobby (Poster exhibition, Coffee)
<b>3rd floor</b>
Aula / Lobby (Registration, Info)
Sali / Room 5 / Parallel
Sali / Room 7 / Parallel
Sali / Room 8 / Parallel
Sali / Room 9 / Speakers
Sali / Room 10 / Parallel
Sali / Room 11 / Organizers
Sali / Room 12 / Parallel
Sali / Room 13 / Parallel *
<b>4th floor</b>
Pieni juhlasali = Small Hall (Opening, closing, key notes) *
* An induction loop can be found from these rooms for individuals using hearing devices

**Figure 2. Rooms, NEW building.**



## THURSDAY 28 August at 09.00 – 09.30 OPENING CEREMONY

## THURSDAY 28 August at 09.30 – 10.30

### KEYNOTE 1. Neo Liberal Epidemics: How politics makes you sick?

Ted Schrecker, Durham University, England

**Ted Schrecker** is Professor of Global Health Policy in the Centre for Public Policy & Health at Durham University (England). His academic background is in political science, and he has taught that discipline as well as environmental studies and population health (at the doctoral level) from an interdisciplinary perspective. For the past decade his research has addressed the consequences of transnational economic integration (globalization) for health and health equity; he also has a long-standing interest in issues at the interface of science, ethics, law and public policy. Ted worked for many years as a legislative researcher and public policy consultant before coming to the academic world.

## PARALLEL SESSIONS I

### THURSDAY 28 August at 11.00 - 12.20

#### Session 1A: HEALTH POLICY AND SERVICES I: Reforms and policy

**Chair: Zofia Slonska, Instytut Kardiologii, Poland**

- 59427 Reforming health systems in the central and eastern Europe in the context of socialist heritage. **Slonska**, Cardinal Stefan Wyszyński Institute of Cardiology, Poland
- 57161 Problematizing Health inequality policy: The English case. **Kriznik**, Durham University, UK
- 57240 The single-option dilemma: A trade-off between epistemic and deontic authority? **Toerien**, University of York, UK
- 57218 Improving health through home energy efficiency. Policy imperatives and reflexive responses. **Bonnington**, London School of Hygiene and Tropical Medicine, UK

#### Session 1B: MENTAL HEALTH I

**Chair: Peija Haaramo, University of Helsinki, Finland**

- 57226 Trajectories of common mental disorders among ageing employees. **Haaramo**, University of Helsinki, Finland
- 56781 Educational differentials in antidepressant use trajectories among depressed individuals. **Moustgaard**, University of Helsinki, Finland
- 56573 Pathways from adolescence family relations to mid-adulthood mental health. **Berg**, National Institute for Health and Welfare (THL), Finland
- 57242 Social inequalities in the emergence and persistence of sleeping problems in Europe's older adults. **Van de Straat**, University of Ghent, Belgium

#### Session 1C: SMOKING I

**Chair: Tomi Mäki-Opas, National Institute for Health and Welfare (THL), Finland**

- 56683 Inequalities in cigarette smoking among men: evidence from a tobacco growing country in Sub-Saharan Africa. **Doku**, University of Cape Coast, Ghana
- 56103 Cultural capital and smoking in young adults: exploring new indicators of social inequalities in health. **Gagné**, Université de Montréal, France
- 57305 Smoking socio-economic inequalities in school-aged teenagers from six European Countries: the role of social networks. **Lorant**, UCLouvain - Institute of Health and Society, Belgium



- 57114 Electronic cigarettes and the use of tobacco products and nicotine replacement therapy: A population-based study. **Ruokolainen**, National Institute for Health and Welfare (THL), Finland

#### Session 1D: INEQUALITIES IN SELF-RATED HEALTH

**Chair: Olaf von dem Knesebeck, University of Hamburg, Germany**

- 56977 Social inequalities in self-rated health in Ukraine. **Platts**, Kings College London, UK  
 57096 Ecological study of relationship between self-rated health and income inequalities in Japanese disaster Area. **Misawa**, Rikkyo University, Tokyo, Japan  
 56766 Social inequalities in patient-reported outcomes among older multimorbid patients. **Von dem Knesebeck**, Department of Medical Sociology, University of Hamburg, Germany  
 55498 Social relations and health in Belarus. **Mäkinen**, Södertörn University, Huddinge, Sweden

#### Session 1E: DISEASE CAREERS I

**Chair: Sara Arber, University of Surrey, UK**

- 59352 Impact of social capital on health and well-being after a cancer diagnosis. **Lehto**, National Institute for Health and Welfare, Helsinki, Finland  
 59423 Inequalities in post cancer social rehabilitation: A qualitative study among young women with breast cancer. **Regnier-Denois**, HYGEE-ICLN, France  
 57153 Social patterning of recovery from physical illness: Patients' experiences of heart attack and leukaemia. **Earthy**, University of Surrey, UK  
 59384 Moral obligations and expectations of adult survivors of childhood liver transplant: Deserving or undeserving recipients? **Lowton**, King's College London, UK

#### Session 1F: PROFESSIONS I

**Chair: Jon Ivar Elstad, NOVA, Oslo and Akershus University College, Norway**

- 57216 Going over to the "dark side"? The vulnerability of medics who manange. **Annandale**, University of York, UK  
 56757 Social inequalities in health-related behaviours promoted by French general practitioners. **Rigal**, Paris Descartes University Paris, France  
 55946 How social ties influence patient's choice and their relationships with health professionals. **Senghor**, LISST, France  
 57195 Cardiovascular risk patients: Clinical strategies, patients' strategies. **Xavier**, New Lisbon University, Nursing School Coimbra, Portugal

## PARALLEL SESSIONS II

**THURSDAY 28 August at 13.30 - 15.00**

#### Session 2A: HEALTH CARE I, pre-organized session: Health care systems and health inequalities 1

**Organizer and chair: Simona Olivadoti and Mara Tognetti Bordogna, University of Milan-Bicocca, Faculty of Sociology, Italy**

- 57038 Educational differences in mortality amenable to health care between health systems. **Fjær**, Norwegian University of Science and Technology, Norway  
 59244 Public expenditure and socioeconomic disparities in influenza vaccination across Europe. **Bristle**, MEA - Max Planck Institute for Social Law and Social Policy, Munich, Germany

## Session 2B: MENTAL HEALTH II

**Chair: Heta Moustgaard, University of Helsinki, Finland**

- 59069 Knowledge relations in psychotherapy interaction. *Weiste*, University of Helsinki, Finland  
59650 Dealing with stigma of mental illness - visual analysis of Chinese and European social campaigns. *Prokop*, Department of Medical Sociology, Chair of Epidemiology and Preventive Medicine, Jagiellonian University Medical College, Krakow, Poland  
56927 Being chronically ill: The socially and relationally structured influences on well-being. *Foubert*, University of Ghent, Belgium

## Session 2C: SMOKING II, pre-organized symposium: Tobacco-free Finland 2040: Equal opportunities for tobacco-free life?

**Organizer and chair: Jaakko Kaprio, University of Helsinki, Finland**

- 54664 Socio-economic differences in smoking initiation in Finland. *Rimpelä*, School of Health Sciences, University of Tampere, Finland  
57179 Socioeconomic differences in smoking cessation: 11 year follow-up from Health2000. *Haukkala*, University of Helsinki, Finland  
58675 The changing contribution of harmful consumption of alcohol and smoking to income differences in life-expectancy. *Martikainen*, University of Helsinki, Finland  
59163 Smokers with mental disorders – An underserved population in tobacco-free initiatives. *Kinnunen*, Harvard University, Faculty of Medicine, USA

## Session 2D: GENDER AND HEALTH I

**Chair: Claudine Burton-Jeangros, University of Geneva, Department of Sociology, Switzerland**

- 56586 Fatherhood, motherhood, gender, 'sharing' and wellbeing, in England. *Williams*, Kings College London, UK  
59353 "The Russian sex": Problems, trends and perspectives in contemporary Russian sexology. *Burmakova*, European University at Saint-Petersburg, Russia  
57157 Male gender role identity and health behaviours: a relational analysis of UK couples. *Meadows*, University of Surrey, UK

## Session 2E: DISEASE CAREERS II

**Chair: Rudolf Forster, Ludwig Boltzmann Institut Health Promotion Research, Vienna, Austria**

- 57214 Sport-illness narratives of people with breast cancer, diabetes and HIV. *Elling*, Mulier Institute  
57325 Educational trajectories after childhood cancer: A contribution to the health selection hypothesis. *Dumas*, Gustave Roussy Institute, Social Sciences Research Unit, France  
56964 Inflammatory rheumatism and chronic kidney failure – comparing their consequences on patient's career trajectory. *Ribeiro*, University of Neuchâtel, Switzerland

## Session 2F: WORK AND WELL-BEING I, pre-organized symposium: Work, health and disability: a life-course approach to labour market participation using register data from Nordic countries

**Organizer and chair: Tea Lallukka, Finnish Institute of Occupational Health, Finland**

- 50623 Psychotropic medication use and risk of work-related injuries. *Kouvonen*, Queen's University Belfast, UK  
51731 The joint contribution of pain and insomnia to work disability among Norwegian and Finnish employees. *Lallukka*, Finnish Institute of Occupational Health, Helsinki, Finland  
55006 Mental health, employment and work disability among younger and older employees. *Virtanen*, Finnish Institute of Occupational Health, Helsinki, Finland  
56920 Psychosocial work environment and risk of depression: Current knowledge and challenges. *Madsen*, National Research Centre for the Working Environment, Denmark  
56942 Mental health, pain and sleep problems as predictors of work disability. *Sivertsen*, Norwegian Institute of Public Health, Norway

# PARALLEL SESSIONS III

## THURSDAY 28 August at 15.30 - 17.00

### Session 3A: HEALTH CARE II, pre-organized session: Health care systems and health inequalities 2

**Organizers and chairs:** Simona Olivadoti and Mara Tognetti Bordogna, University of Milan-Bicocca, Faculty of Sociology, Italy

- 56911 A cross-national comparative study on the role of individual life course factors on mammography screening. *Missinne*, University of Ghent, Department of Sociology, Belgium
- 56996 Equality and inequality in health care: the case of mental health, *Cersosimo*, University of Salerno, Italy
- 59083 Informal payment in the Hungarian health sector. Sociology of non-reform. *Eröss*, Centre for Social Sciences, Hungarian Academy of Sciences, Hungary

### Session 3B: MENTAL HEALTH III

**Chair:** Eero Lahelma, University of Helsinki, Finland

- 55730 Common mental disorders and subsequent mortality. *Lahelma*, University of Helsinki, Hjelt Institute, Department of Public Health, Helsinki, Finland
- 57287 The impact of unintended pregnancy on depressive mood in Europe. *Dereuddre*, Ghent University, Belgium
- 57212 Psychiatric disorders among middle-aged couples and the risk of subsequent divorce. *Metsä-Simola*, University of Helsinki, Finland
- 59233 Drinking habits and mental health functioning - a prospective study among ageing employees. *Salonsalmi*, University of Helsinki, Finland

### Session 3C: HEALTH POLICY AND SERVICES II

**Chair:** Sakari Karvonen, National Institute for Health and Welfare (THL), Finland

- 57379 'Love them or hate them': the 'arrogant bubble' and dis/trust in the postsocialist birth care system. *Hresanova*, University of West Bohemia, Czech Republic
- 59405 The janus-faced anatomy technician: Liaising with families of whole body donors to medical sSchools. *Seymour*, Hull York Medical School, UK
- 57246 Failure to promote the cause of organ donation: The case of patients' associations in Switzerland. *Hammer and Kaech*, University of Health Sciences, Lausanne, Switzerland
- 59413 Value-for-money regulation of expensive new medicines: Legitimizing decisions through the transformation of uncertainty? *Brown*, University of Amsterdam, Netherlands

### Session 3D: GENDER AND HEALTH II

**Chair:** Anu Katainen, University of Helsinki, Finland

- 56881 The social challenges of medically assisted procreation in Italy. Gender relationships between change and inequalities. *Lombardi*, University of Milan; ISMU Foundation, Italy
- 56951 The gynaecologist's gaze: The inconsistent medicalization of contraception in contemporary Russia. *Temkina*, European University at St. Petersburg, Russia
- 56572 Communication of caregivers with terminally-ill cancer patients about illness and death: Gender differences. *Carmel*, Ben-Gurion University, Israel
- 55617 Intersectionality and underrepresentation in a healthcare workforce: the case of Arabs in Israel. *Keshet*, Western Galilee Academic College, Israel

### Session 3E: DISEASE CAREERS III

**Chair:** Piet Bracke, University of Ghent, Belgium

- 57022 Screening for colorectal cancer: Lifestyle bridging chances and choices. *Feder-Bubis*, Ben-Gurion University of the Negev, Israel

- 57445 Multiple socioeconomic determinants of noncommunicable disease risk factors: Example of the former Soviet Union Countries. **Chimed**, School of Health Sciences, University of Tampere, Finland
- 56826 Structural and behavioural explanations of tuberculosis in Latvia. **Ivanovs**, Riga Stradins University, Latvia
- 57003 Parents resisting to mandatory vaccination - (re)defining the boundaries of lay and expert knowledge. **Hasmanova Marhankova**, Charles University in Prague, Czech Republic

### **Session 3F: WORK AND WELL-BEING II: Work ability**

**Chair: Ossi Rahkonen, University of Helsinki, Finland**

- 57125 Three decades of work ability in Finland -population attributable fraction. **Kaikkonen**, National Institute for Health and Welfare (THL), Finland
- 57188 Occupational competence and work ability from young adulthood to early midlife: a 15-year longitudinal study. **Seitsamo**, Finnish Institute of Occupational Health, Finland
- 53671 Stress in household and family work – a neglected issue of health inequality in women? **Sperlich**, Medical Sociology, Hannover Medical School, Germany
- 56789 Working longer: paid employment after age 65 years. **Wahrendorf**, Centre for Health and Society, Institute for Medical Sociology, University of Düsseldorf, Germany

## **PARALLEL SESSIONS IV**

**FRIDAY 29 August at 08.30 - 10.00**

### **Session 4A: Pre-organized session: RECESSION AND HEALTH IN EUROPE I: Austerity, liberatization and health.**

**Chair and organizer: Tim Huijts, University of Oxford, UK**

- 59386 What price austerity: A nation's health. **Kiernan**, Mater Hospital, Dublin, Ireland
- 56704 Trade liberalization and health: The mfa phase-out and changes in adult and infant mortality rates. **McNamara**, University of York, Department of Social Policy and Social Work, UK
- 57145 (Un)employment and mental health care use assessed by macro-socioeconomic context and change influences. **Buffel**, University of Ghent, Belgium

### **Session 4B: HEALTH CARE III**

**Chair: Sakari Karvonen, National Institute for Health and Welfare (THL), Finland**

- 59232 Socioeconomic patterns in use of private and public health services in Spain, 1987-2007. **Lostao**, Universidad Pública de Navarra, Portugal
- 56943 How do changes in personal income affect use of private health care in Finland? **Blomgren**, the Social Insurance Institution of Finland, Research Department, Finland
- 57027 Social inequality in utilization of outpatient psychotherapy. **Jaunzeme**, Medical Sociology, Hannover Medical School, Germany

### **Session 4C: Pre-organized session: PHYSICAL ACTIVITY – SOCIAL DETERMINANTS AND CONSEQUENCES I**

**Organizer and chair: Tomi Mäki-Opas, National Institute for Health and Welfare (THL), Helsinki, Finland**

- 57926 Off the beaten paths. **Abel**, University of Bern, Switzerland
- 56907 Environmental determinants for commuting physical activity in Finland. **Mäki-Opas**, National Institute for Health and Welfare (THL), Helsinki, Finland
- 50173 An intersectional approach to inequalities in physical activity by race, gender, class and sexuality. **Veenstra**, University of British Columbia, UK
- 56940 Leisure-time physical activity and mortality. **Lahti**, University of Helsinki, Finland

#### **Session 4D: Pre-organized symposium: UNDOING PSYCHO-PATOLOGISATION**

**Organizer and chair: Elizabeth McDermott, Lancaster University, UK**

- 53454 'Genuine' or a 'cry for help'? General practitioner's accounts of treating self-harm. **Chandler**, University of Edinburgh, UK
- 57221 Embodying distress: Emotional and relational work done by LGBTQ youth who self-harm. **Roen**, Department of Psychology, University of Oslo, Norway
- 57275 'It's just hormones': help-seeking, self-harm and LGBT youth. **McDermott**, Lancaster University, UK

#### **Session 4E: HEALTH POLICY AND SERVICES III**

**Chair: Jon Ivar Elstad, NOVA, Oslo and Akershus University College, Norway**

- 56753 Avoidable hospitalization rates in Norway – equal for immigrants and natives? **Elstad**, NOVA, Oslo and Akershus University College, Norway
- 57142 Why were they admitted? Exploring hospital admissions of patients close to the end of life. **Hoare**, University of Cambridge, UK
- 55696 Informality in hospital organizations - obstacle or motor? Results from nine northeastern German hospitals. **Elkeles**, University of Applied Sciences Neubrandenburg, Germany
- 56900 When health service contributes to health inequalities: The case of gynecological cancers screening in France. **Bloy**, University of Burgundy/CNRS, France

#### **Session 4F: YOUNG PEOPLE I: inequalities and life-course**

**Chair: Laura Kestilä, National Institute for Health and Welfare (THL), Helsinki, Finland**

- 59446 Educational systems and health inequalities among young people: A multilevel analysis in 34 countries. **Rathmann**, Medical Faculty, Institute of Medical Sociology, Martin-Luther-University Halle-Wittenberg, Germany
- 56934 Social inequalities in adolescent health complaints from 1994-2010: International trends from the HBSC study. **Moor**, Institute of Medical Sociology, Martin-Luther-University Halle, Germany
- 57202 Changes in health behavior among Russian youth during country's transition. **Verho**, National Institute for Health and Welfare (THL), Helsinki, Finland
- 57267 Is being a "small-fish-in-a-big-pond" bad for student health? Classmates' achievement-level and subjective health in Germany. **Rathmann**, Medical Faculty, Institute of Medical Sociology, Martin-Luther-University Halle-Wittenberg, Germany

#### **Session 4G: GENDER AND HEALTH III**

**Chair: Zofia Slonska, Instytut Kardiologii, Poland**

- 57241 Do Indian girls face a nutritional disadvantage? Gender disparities in breastfeeding and food consumption. **Fledderjohann**, University of Oxford, UK
- 57251 Women as mothers and nurturers: Unraveling the relationship between gender equality, education and breastfeeding (Belgium). **Vanderlinden**, Ghent University, Belgium
- 56953 Re-embodying ultrasound: Women's accounts of fetal sonograms prior to abortion in England. **Beynon-Jones**, Department of Sociology, University of York, UK

## **PARALLEL SESSIONS V**

**FRIDAY 29 August at 10.20 - 11.50**

#### **Session 5A: Pre-organized session: RECESSION AND HEALTH IN EUROPE II: Social policy and health inequalities**

**Organizer and chair: Tim Huijts, University of Oxford, UK**

- 57257 Do sickness benefit arrangements buffer against the health risks of hazardous work and low education? **Van der Wel**, Oslo and Akershus University College of Applied Sciences, Norway



- 59443 Recession and adolescent health inequalities: Do social benefits buffer health inequalities in the “lost generation”? **Rathmann**, Medical Faculty, Institute of Medical Sociology, Martin-Luther-University Halle-Wittenberg, Germany
- 57738 Job loss and health: the mitigating effect of social protection expenditure in 23 European countries. **Huijts**, University of Oxford, UK
- 59365 Economic crisis, social policy and health inequalities: a systematic review of the research literature. **Dahl**, Oslo and Akershus University College, Norway

#### **Session 5B: Pre-organized session: INFORMAL CAREGIVING I**

**Organizer and chair: Ellen Verbakel, Department of Sociology, Radboud University Nijmegen, Netherlands**

- 53996 ‘Alert Assistants’ and ‘Substitute Parents’: The role of siblings in the management of childhood epilepsy. **Webster**, Royal Holloway, University of London, UK
- 56975 The experience of adult daughters caring for their frail older parents: A longitudinal phenomenological study. **Lopez Hartman**, University of Antwerp, Belgium
- 51403 Stigma by association among informal carers of people diagnosed with bipolar or borderline personality disorder. **Bonnington**, London School of Hygiene and Tropical Medicine, UK
- 57223 Caregiving by family members. **Brzyska**, Jagiellonian University Medical College, Poland

#### **Session 5C: Pre-organized session: PHYSICAL ACTIVITY – SOCIAL DETERMINANTS AND CONSEQUENCES II**

**Organizer and chair: Tomi Mäki-Opas, National Institute for Health and Welfare (THL), Helsinki, Finland**

- 51578 Income, physical activity and the compression of morbidity. An analysis for older people in Germany. **Trachte**, Hannover Medical School, Germany
- 56965 Retirement and changes in leisure-time physical activity: a follow-up study. **Holstila**, University of Helsinki, Hjelt Institute, Department of public health, Finland
- 56615 Association of physical workload and leisure time physical activity with incident mobility limitation. **Mänty**, University of Helsinki, Hjelt Institute, Department of public health, Finland
- 59381 Mobility enhancement in residential aged care – promoting physical activity in a highly vulnerable group. **Quehenberger**, Ludwig Boltzmann Institut Health Promotion Research, Austria

#### **Session 5D: WORK AND WELL-BEING III**

**Chair: Ossi Rahkonen, University of Helsinki, Finland**

- 56924 Trajectories of antidepressant medication before and after the onset of unemployment. **Leinonen**, University of Helsinki, Finland
- 57249 The wellbeing of the long-term unemployed in western uusimaa county. **Tuohimaa**, Laurea University of Applied Sciences, Finland
- 59376 Employment, health, and well-being. evidence from the Paltamo employment model evaluation. **Leemann**, National Institute for Health and Welfare (THL), Finland
- 57158 THE EVOLUTION OF THE EMPLOYMENT QUALITY OF THE EUROPEAN YOUTH DURING THE PERIOD 2000-2010. **Vanroelen**, Department of Sociology, Vrije Universiteit Brussel, Belgium

#### **Session 5E: Pre-organized session: NATIONAL HEALTH TRANSITIONS INDICATED BY THE CHANGE IN MAIN CAUSES OF HOSPITALIZATION**

**Organizer and chair: Ari Väänänen, Finnish Institute of Occupational Health, Finland**

- 57127 General transition in hospitalizations in Finland from the mid-1970s to 2010: societal and theoretical background. **Väänänen**, Finnish Institute of Occupational Health, Finland
- 50620 National trends in main causes of hospitalisation in the Finnish working-age population. **Kouvonen**, Queen's University Belfast, UK
- 57133 Long-term trends in main causes of hospitalization among six occupational groups in Finland, 1976–2010. **Varje**, Finnish Institute of Occupational Health, Finland
- 57207 Differences in hospitalization ratios between employment industries, Finland 1976-2010. **Kokkinen**, Finnish Institute of Occupational Health, Finland

#### **Session 5F: YOUNG PEOPLE II: Inequalities and life-course**

**Chair: Laura Kestilä, National Institute for Health and Welfare (THL), Finland**

- 58722 Parental social and health-related risk factors for poisoning and intentional injuries among adolescent children. *Remes*, University of Helsinki, Finland
- 53461 Parental education, own education and self-rated health in Germany: Evidence from three life-course models. *Kuntz*, Robert Koch Institute, Berlin, Germany
- 57166 Family economic hardships during recession predict child's economic and psychiatric outcomes in young adulthood. *Kiviruusu*, National Institute for Health and Welfare (THL), Finland
- 57164 Register-based project on harms to children caused by parents' substance misuse. *Jääskeläinen*, Finnish Foundation for Alcohol Studies / National Institute for Health and Welfare, Finland

### **FRIDAY 29 August at 13.00 – 14.00**

#### **KEYNOTE 2. Health Inequalities in Southern Europe in a period of economic crisis**

**Carme Borrell, Public Health Agency of Barcelona, Spain**

**Carme Borrell**, MD, PhD works at the Public Health Agency of Barcelona (Spain) in the Health Information Systems Service. Her research for the last 25 years has been related with the study of social determinants of health having published many articles and leded national and international projects. Now she is leading a project funded by the EU 7th framework: the Sophie project on Evaluating the Impact of Structural Policies on Health Inequalities and their Social Determinants, and Fostering Change.

## **PARALLEL SESSIONS VI**

### **FRIDAY 29 August at 15.00 - 16.20**

#### **Session 6A: Pre-organized session: RECESSION AND HEALTH IN EUROPE III: Macro-economic change and health**

**Organizer and chair: Tim Huijts, University of Oxford, UK**

- 57324 “Fundamental cause” of social inequality in health and financial crisis in Spain. *Zapata Moya*, Public Health & Preventive Medicine Area. University of Pablo Olavide, Seville, Spain
- 57167 The europeanization of living conditions and health. *Israel*, University of Oldenburg, Germany
- 57256 The gendered impact of the current economic crisis on depression in Europe. *Buffel*, University of Ghent, Belgium

#### **Session 6B: Pre-organized session: INFORMAL CAREGIVING II**

**Organizer and chair: Ellen Verbakel, Department of Sociology, Radboud University Nijmegen, Netherlands**

- 54086 Networks of informal caring: a mixed methods approach. *Rutherford*, University of Stirling, UK
- 56175 Why caregivers institutionalize family members; examining gender and relationship intersections. *Chappell*, University of Victoria, Canada
- 57233 Understanding Dutch informal caregiver's well-being: adjustments of the stress/appraisal model. *Verbakel*, Department of Sociology - Radboud University Nijmegen, Netherlands

### Session 6C: HEALTH AND AGEING I

**Chair: Eero Lahelma, University of Helsinki, Finland**

- 62562 Social determinants, life course and health service use in a situation of ageing dependency. *Cassan*, CLERSE -Lille University, France
- 57151 Older people's vulnerability to and risk of foodborne illness in the home setting. *Wills*, university of Hertfordshire, UK
- 54001 Ageism in an ageing society: perspectives on young people. *Curtis*, University of Sheffield, UK
- 59371 Predicting mobility limitations using a repeated measurements population survey data. *Härkänen*, National Institute for Health and Welfare (THL), Finland

### Session 6D: HEALTH AND IMMIGRANTS I

**Chair: Annika Lillrank, University of Helsinki, Finland**

- 57283 The east in the north – an ecology of health in a northern English city. *Small*, University of Bradford, UK
- 57049 Clustering of negative life events and cardiovascular disease risk among immigrants in Finland. *Skogberg*, National Institute for Health and Welfare (THL), Finland
- 57119 Identity constructions of muslims with mental health problems: A theoretical investigation. *Rondelez*, University of Ghent, Belgium

### Session 6E: HEALTH PROMOTION AND SERVICES I

**Chair: Karl Krajic, Ludwig Boltzmann Institut Health Promotion Research, Vienna, Austria**

- 59223 Transforming residential aged care into a health promoting setting? Results from an Austrian pilot project. *Krajic*, Ludwig Boltzmann Institute Health Promotion Research, Vienna, Austria
- 59403 Community development and empowerment for health: Public health action and its evaluation. *Suess*, Universitätsklinikum Hamburg-Eppendorf (UKE), Germany
- 57141 The personal wellbeing pathway model for holistic, citizen centric and health promotive care. *Tuohimaa*, Laurea University of Applied Sciences, Finland
- 59354 Oncologic diseases: Two sides of the same coin. *Silva*, IPATIMUP, Portugal

### Session 6F: MORTALITY I

**Chair: Hanna Remes, University of Helsinki, Finland**

- 54407 The second mortality transition: A new look at long term trends in mortality decline. *Anson*, Ben-Gurion University of the Negev, Israel
- 57217 Why and how have inequalities in mortality emerged? Cause-specific mortality in a middle-income European country. *Kovacs*, Demographic Research Institute, Budapest, Hungary
- 59129 Socioeconomic differences in cause-specific mortality after disability retirement due to different diagnoses. *Polvinen*, Finnish Centre for Pensions, Finland
- 49891 Socio-demographic determinants and place of death: a retrospective analysis using administrative data from Switzerland. *Hedinger*, University of Zurich, Switzerland

## PARALLEL SESSIONS VII

**FRIDAY 29 August at 16.30 - 18.00**

### Session 7A: Pre-organized session: COMPARATIVE RESEARCH AND HEALTH INEQUALITIES

**Organizers and chairs: Piet Bracke and Sarah van de Velde, University of Ghent, Belgium**

- 57268 Reducing the double burden in dual earner families by degenderizing child care responsibilities in Europe. *Van de Velde*, University of Ghent, Belgium
- 54113 Do financial strain and labour force status explain Nordic countries' relatively wide health inequalities? *Shaw*, MRC/CSO Social and Public Health Sciences Unit, University of Glasgow, UK
- 57282 Ready, willing and able: The determinants of using modern contraception in Europe. *Dereuddre*, University of Ghent, Belgium



### **Session 7B: INFORMAL CAREGIVING III**

**Chair: Sara Arber, University of Surrey, UK**

- 57122 Correlation between sociodemographic characteristics and parental health literacy in different regions of Hungary. **Gács**, Semmelweis University, Budapest, Hungary
- 59173 Influence of caregiving on sleep quality in working life and later life. **Arber**, University of Surrey, UK
- 67244 Support measures for informal caregivers. Qualitative study in five European countries. **Willemse**, University of Antwerpen, Belgium

### **Session 7C: LIFE-STYLE**

**Chair: Anu Katainen, University of Helsinki, Finland**

- 59401 Sociocultural dimensions of socioeconomic health disparities: Focus on agency. **Maunu**, Finnish Association for Substance Abuse Prevention, Finland
- 57209 How lifestyle became the dominant explanation for type 2 diabetes: a historical analysis. **O'Donnell**, University College Dublin, Ireland
- 59373 Pharmaceuticalisation of drug cultures? Polydrug use and user networks on the internet. **Rönkä**, University of Helsinki, Department of Social Research, Finland
- 59426 Social representations of health in relation to health-related-lifestyle of the middle class in Poland. **Borowiec**, The Cardinal Stefan Wyszyński Institute of Cardiology, Poland

### **Session 7D: HEALTH AND IMMIGRANTS II**

**Chair: Annika Lillrank, University of Helsinki, Finland**

- 59654 Refugee women's health care experiences regarding pregnancy and birth in Finland. **Lillrank**, Swedish School of Social Science, University of Helsinki, Finland
- 57321 The health status of migrant women in Lombardy: Rights and access to health care services. **Lombardi**, University of Milan, ISMU Foundation, Italy
- 55995 The role of physical functioning in explaining the work ability of migrants in Finland. **Rask**, National Institute for Health and Welfare, Finland

### **Session 7E: HEALTH PROMOTION AND SERVICES II**

**Chair: Rudolf Forster, Ludwig Boltzmann Institut Health Promotion Research, Vienna, Austria**

- 56950 Cam practitioners' strategies to achieve occupational closure in the Portuguese healthcare system. **Almeida**, Royal Holloway University of London, UK
- 56048 Early entrance to childcare and changing childcare places associated with children's overweight in Finland. **Roos**, Folkhälsan Research Center, Finland
- 56737 Lay participation in health-related decisions: a selective review of frameworks and an alternative conceptualization. **Forster**, Ludwig Boltzmann Institut Health Promotion Research
- 54366 Cancer fundraising: Addressing vulnerabilities? **Barbour**, the Open University, UK

### **Session 7F: WORK AND WELL-BEING IV: Working conditions**

**Chair: Tea Lallukka, Finnish Institute of Occupational Health, Finland**

- 59318 Decreasing job quality in Europe? The evolution of job strain and ergonomic strain between 1995 and 2010. **Vanroelen**, Department of Sociology, Vrije Universiteit Brussel, Belgium
- 57005 Inequality of exposure to occupational risks in Europe and the theory of equalising differences. **Montano**, Faculty of Medicine, Duesseldorf University, Germany
- 56787 Does stressful work contribute towards explaining socioeconomic differences in mental health? A systematic analysis. **Hoven**, University of Duesseldorf, Germany
- 56906 Occupational inequalities in environmental tobacco smoke exposure at work: European comparisons. **Dragano**, Institute for Medical Sociology, Centre for Health and Society, Medical Faculty, University of Düsseldorf, Germany

**SATURDAY 30 August at 09.30 – 10.15**

**KEYNOTE 3. How marketization policies challenge professionalism of care in Western Europe: Subservient past, subservient future for the care workforce?**

**Sirpa Wrede, University of Helsinki, Finland**

**Sirpa Wrede** is a Senior Lecturer and a Docent of Sociology at the University of Helsinki. In addition to research on the impact of globalisation on professions and professional work as well as on ethnic relations in working life, her research areas include the welfare state and welfare-state restructuring. Furthermore, she has written on the use of qualitative methods in international comparative research. She is principal investigator and leader of the Academy of Finland project The Shaping of Occupational Subjectivities of Migrant Care Workers: A Multi-Sited Analysis of Globalising Elderly Care (2011-2015).

**PARALLEL SESSIONS VIII**

**SATURDAY 30 August at 10.30 - 12.00**

**Session 8A: MORTALITY II**

**Chair: Netta Mäki, University of Helsinki, Finland**

- 56063 Premature mortality after suicide attempt and the risk in relation to socioeconomic status in Finland. **Mäki**, University of Helsinki, Finland
- 56763 Never married, ever married, always married? Marital histories and risk of MI incidence and fatality. **Kilpi**, University of Helsinki, Finland
- 57206 Educational inequalities in mortality in Sweden 1990-2009: The role of family type and income. **Östergren**, Stockholm University, Sweden

**Session 8B: PROFESSIONS II: Nursing**

**Chair: Charlotte Sercu, University of Ghent, Belgium**

- 57348 Empowerment figures of the nursing profession. **Toffel**, Haute Ecole de Santé Vaud, Lausanne, Switzerland
- 55910 From care to comprehensive and customized solutions: The changing role of Finnish occupational health nurses. **Koskela**, Finnish Institute of Occupational Health, Finland
- 57156 Issues involved in the struggles within the nursing profession. A structural approach. **Longchamp**, Haute Ecole de Santé Vaud (HESAV), Lausanne, Switzerland
- 55919 How does stigma influence mental health nursing identities? An ethnographic study. **Sercu**, Ghent University, Belgium

**Session 8C: HEALTH AND AGEING II**

**Chair: Claudine Burton-Jeangros, University of Geneva, Department of Sociology, Switzerland**

- 57208 Social networks characteristics and quality of life in older age. Polish data based on COURAGE. **Tobiasz-Adamczyk**, Department of Medical Sociology, Chair of Epidemiology and Preventive Medicine, Jagiellonian University Medical College, Krakow, Poland
- 56578 Health losses and life satisfaction: A longitudinal study of elderly Israelis. **Carmel**, Ben-Gurion University, Israel
- 59387 Age-related hearing loss and subjective well-being: The role of social participation decline. **Andrade**, Institute of Ageing, Portugal
- 71792 Life satisfaction trajectories in elderly women living in Switzerland. **Burton-Jeangros**, University of Geneva, Department of sociology, Geneva, Switzerland

**Session 8D: GENDER AND HEALTH IV**

**Chair: Anu Katainen, University of Helsinki, Finland**

- 59162 Nature vs. technology, medicalization vs. demedicalization – home birth as seen by women and midwives. **Doroszewska**, Medica University of Warsaw, Poland

- 56958 Language of science and language of love: The legitimation of independent midwifery practice in Russia. **Borozdina**, European University at St. Petersburg, Russia
- 57170 "Childbirth with dignity" campaign as opposition to "totalitarian obstetrics". Demedicalization of perinatal care in Poland. **Piątkowski**, Medical University of Lublin, Independent Unit of Medical Sociology, Lublin, Poland

#### **Session 8E: NUTRITION AND WEIGHT**

**Chair: Ritva Prättälä, National Institute for Health and Welfare (THL), Finland**

- 57120 From margarine to butter - predictors of changing bread spread in an 11-year population follow-up. **Prättälä**, National Institute for Health and Welfare (THL), Finland
- 57245 What do children drink when they do not receive water? Beverage consumption in India. **Fledderjohann**, University of Oxford, UK
- 57307 European time trends in self-perceived weight: results from hbsc study 2002–2010. **Ojala**, University of Jyväskylä, Finland
- 56941 "It helps to understand eating numerically". The practice of dieting with an online slimming service. **Niva**, National Consumer Research Centre, Finland

#### **Session 8F: METHODS**

**Chair: Tommi Härkänen, National Institute for Health and Welfare (THL), Finland**

- 57152 Assigning the education of one spouse to the other when analyzing health insurance data. **Muschik**, Medical Sociology Unit - Hannover Medical School, Germany
- 59133 Modeling point data: self-rated health and the experience of unsafety in Helsinki as case examples. **Kemppainen**, University of Helsinki, Finland
- 59239 Correcting the effects of non-response in the reimbursed medication estimates in the ATH survey. **Härkänen**, National Institute for Health and Welfare (THL), Finland
- 57231 The effect of changes in household income on sickness allowance days – random-intercept models. **Aittomäki**, University of Helsinki, Finland

## **CLOSING SESSION, AWARDS**

**SATURDAY 30 August at 12.30 – 13.00, Small Hall**

# POSTER SESSION

## FRIDAY 29<sup>th</sup>, 14.00-15.00

Chairs: TBC

- 59430 Alastalo:** Health impact assessments of government bills on taxation. University of Tampere, School of Health Sciences, Finland
- 57222 Anthierens (Fraeyman):** Perceptions of chronic disease patients about medicine prices in times of austerity. University of Antwerpen, Belgium
- 57030 Bicocchi:** Telemedicine as an example of the transnational sharing of 'common good' welfare: the Jimuel Project. Università di Pisa, Italy
- 57193 Claeys:** Dischargemanagement: barriers and role of nurses and midwives for ethnically and socioeconomic deprived. Erasmus University College, Brussels, Belgium
- 54662 Diehl:** Physical activity counseling for cardiovascular disease prevention: A nationwide survey among primary care physicians. Mannheim Institute of Public Health, Social and Preventive Medicine, Germany
- 56591 Diehl:** Sunbed use in minors despite a legal ban: Results from the SUN-Study 2012. Mannheim Institute of Public Health, Social and Preventive Medicine, Germany
- 56594 Diehl:** Gynecologists' attitudes towards the screening of gestational diabetes recently included in the German maternity directive. Mannheim Institute of Public Health, Social and Preventive Medicine, Germany
- 56987 Faraci:** Governance into Italian health care system: insufficiency of citizens' participation or lack in organizational culture? University of Florence, Italy
- 55026 Freidl:** Unemployment, social justice and health. Medical University of Graz, Austria
- 55679 Hoebel:** Measuring subjective social status in social epidemiology: construct validity of the MacArthur scale. Robert Koch Institute, Berlin, Germany
- 57375 Jirkovska:** Health promotion of staff in long term care - probe in the Czech Republic. Department of Sociology, Charles University in Prague, Czech Republic
- 55355 Krause:** Are overweight and obesity related to poor self-rated health among adolescents in Germany? Robert Koch Institute, Berlin, Germany
- 57965 Kroll:** Socioeconomic differences in smoking, physical inactivity and obesity among 18-79 years adults in Germany. Robert Koch Institute, Berlin, Germany
- 57227 Lahelma (Pietiläinen):** Occupational class inequalities in sickness absence after hospitalization. University of Helsinki, Finland
- 59229 Loizou:** Stigma experience of thalassemia patients in Cyprus. Research Unit in Behaviour and Social Issues (RUBSI), Cyprus
- 57126 Murto (Kaikkonen):** Regional and city-level health and wellbeing differences in Finland 2013. National Institute for Health and Welfare (THL), Finland
- 56018 Nevanperä:** Obesity and work ability in midlife: a prospective cohort study. Finnish Institute of Occupational Health, Finland
- 57178 Nevanperä:** Lifetime health behaviors and work ability in midlife: A prospective cohort study. Finnish Institute of Occupational Health, Finland
- 59435 Regnier-Denois:** Social representations of cancer in 9 to 12 years old children: a qualitative study. HYGEE-ICLN, France
- 56089 Resch:** Health literacy & active ageing education. Die Berater, Vienna, Austria
- 49177 Resch:** Competences for driving a car in old age. Results of an interview study. Die Berater, Vienna, Austria
- 51226 Rommel:** Workplace injuries (Wi) - socio-demographic, occupational and health related determinants. Robert Koch Institute, Germany
- 75423 Shemeikka:** Regional differences in health and health behavior among young adults in Finland. Kuntoutussäätiö, Finland
- 56786 Sumanen:** 13 year trends in sickness absence among young municipal employees. University of Helsinki, Hjelt Institute, Finland
- 57176 Wozniak:** The level of religiousness as a predictor of psychological and social well-being in older people. Jagiellonian University Medical College, Krakow, Poland

## Abstracts

### PARALLEL SESSIONS I

**THURSDAY 28 August at 11.00 - 12.20**

#### **Session 1A: HEALTH POLICY AND SERVICES I: Reforms and policy**

**Chair:** Zofia Slonska, Instytut Kardiologii, Poland

**59427**

#### **REFORMING HEALTH SYSTEMS IN THE CENTRAL AND EASTERN EUROPE IN THE CONTEXT OF SOCIALIST HERITAGE**

*Zofia Slonska*

Cardinal Stefan Wyszyński Institute of Cardiology, Poland

**INTRODUCTION:** By the political turn 1989/1990 health systems in the CEE countries functioned in accordance with the Siemaszko model. As a result of unrealistic premises the model was never successfully implemented and even was a source of pathology in the health systems. The aim of this presentation is to present barriers of transformation of the CEE health systems after the turn 1989/1990, having roots in the Siemaszko ideology.

**METHODS:** Data covered by analysis come from country reports included in the European Observatory on Health Care Systems and from the WHO Health for All Data Base and refer to the period between 1989 and nowadays. To make the comparison more consistent the number of analyzed CEE countries was limited to the EU members.

**RESULTS AND CONCLUSIONS:** The results indicate the strong influence of pathology associated with the Siemaszko ideology on the health system reforming, as evidenced by persistent defects in the CEE health systems, e.g. hospital centered health care systems with an excessive hospital capacity accompanied by weak primary health care, weak public health, and weak health promotion and disease prevention, the shortage of effective mechanisms of the system control and an ineffective system of health workers remuneration. Despite of great progress in reforming the health systems in CEE countries still they have important problemmes to be solved. Due to the social nature of many of these problems is a much needed contribution of medical sociology in solving them.

**57161**

#### **PROBLEMATIZING HEALTH INEQUALITY POLICY: THE ENGLISH CASE**

*Natasha Kriznik*

Durham University, UK

**INTRODUCTION:** The development and analysis of health policy tends to focus on comparing solutions and improving interventions at the expense of considering the political nature of policy-making. Policies do not simply respond to problems but instead actively create representations of problems, which include underlying normative concerns and assumptions about society. These representations impact on both the understanding of the problem, in this case health inequality, and actions which are taken to solve it.

**METHODS:** This study used Bacchi's (2009) "What's the problem?" approach in an analysis of English health policy publications from 1980-2011 in order to question policy representations of the problem of health inequality. Discourse analysis was used to examine how health inequality had been problematized over this period, paying attention how the issue was described and framed through identifying key discourses which shaped policy discussion.

**RESULTS:** Three ways of conceptualising the problem of "differences in health" across the time period studied were discovered: "variations in health"; "systematic variations in health"; and "health inequality". Furthermore, three different understandings of health inequality were present in New Labour's health policy which could be broadly defined as "health disadvantage", the "health gap" and "social gradient in health". These labels were found to be related to different political normative concerns which clearly framed policy discussions, even to the extent of excluding alternative explanations.

**CONCLUSIONS:** By actively questioning policy representations of problems we can move beyond the simple comparison of solutions at different points in time. The problems discussed and solutions offered can be placed within a wider political context which allows us to examine why certain conceptions of “health inequality” emerge at particular points in time. In turn this provides a history of key discourses which shape policy understandings of health inequality.

**57240**

**THE SINGLE-OPTION DILEMMA: A TRADE-OFF BETWEEN EPISTEMIC AND DEONTIC AUTHORITY?**

*Merran Toerien*<sup>1</sup>

*Rebecca Shaw*<sup>2</sup>

*Rod Duncan*<sup>3</sup>

*Markus Reuber*<sup>4</sup>

<sup>1</sup> University of York, UK

<sup>2</sup> University of Glasgow, UK

<sup>3</sup> Christchurch Hospital

<sup>4</sup> University of Sheffield

**INTRODUCTION:** The principle that clinicians ought to involve patients in decision-making is widely accepted in policy and good practice frameworks. Yet there is a lack of evidence-based guidance on how such principles may be enacted in practice.

**METHODS:** Using the fine-grained, qualitative methods of conversation analysis, this study examined over 200 recorded neurology consultations in order to identify recurrent practices used to offer patients choice.

**RESULTS:** We report one such practice – ‘patient view elicitors’ (PVEs) – used to offer choice about a single course of action. The PVEs fell into two groups: those where relevant information was introduced prior to the PVE, and those where it was not. We illustrate both, showing how they function to place the decision in the patient’s domain. However, we show how each raises a difficulty for patient choice: PVEs produced after information provision run the risk of being treated by patients as recommendations (not a matter of choice) because the information may be heard as an indicator of what the clinician thinks is best. By leaving out the prior information, clinicians may avoid this risk. However, they may, instead, leave the patient ill-equipped to respond to the PVE (due to a lack of knowledge).

**CONCLUSIONS:** Drawing on the concepts of epistemic and deontic authority (see Stevanovic and Peräkylä, 2012), we argue that our findings indicate a dilemma for clinicians when introducing choice about a single option: as the epistemic gradient is reduced, so the deontic force may be increased, setting up a trade-off between information provision and facilitating patients’ right to make decisions for themselves. We conclude by demonstrating some possible solutions.

**57218**

**IMPROVING HEALTH THROUGH HOME ENERGY EFFICIENCY? POLICY IMPERATIVES AND REFLEXIVE RESPONSES**

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This paper explores reflexivity theory and social practice theory in the case of home energy efficiency (HEE) installations. HEE installations, such as insulation, double glazing and new heating systems, link to three main policy imperatives. First, the National Cold Weather Plan for England highlights them as key to reducing excess winter mortality and morbidity. Second, their installation is important for climate change mitigation. Third, they are significant in the fight against fuel poverty and its related health effects. But how do these items become domesticated and how can this be increased in order to achieve these broad policy aims? Drawing upon qualitative research with households from a range of social backgrounds in three areas of the UK who have recently installed such items or are thinking about installing them, both Margaret Archer’s theoretical insights into reflexivity and the theory of social practice, derived in large part from Anthony Giddens, are used to understand why HEE items are brought into the home and what effect they have on pathways to health. In the process, critical comment is provided on the compatibility and utility of a critical realist notion of reflexivity and a somewhat central conflationist practice theory. Sociological public health research might currently be seeing a ‘practice turn’, where theoretical focus shifts from the interplay of structure and agency, to a focus on the interweaving of practices and analysis of



individual practice assemblages. But where does this leave the role of reflexivity - the mediator of the parts and the people - if somewhat de-personalised routine configurations take centre stage? Can practice theory adequately account for social change without affording reflexivity its say? And does it matter that practice elements are quintessential confluences of culture, structure, agency and objects? The paper will conclude with tentative explorations of these vital questions.

## **Session 1B: MENTAL HEALTH I**

**Chair: Peija Haaramo, University of Helsinki, Finland**

**57226**

### **TRAJECTORIES OF COMMON MENTAL DISORDERS AMONG AGEING EMPLOYEES**

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*Eero Lahelma*

*Maria Pelgö*

*Ossi Rahkonen*

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**INTRODUCTION:** Poor mental health impairs functioning and work ability. We examined trajectories of common mental disorders and factors affecting them among middle-aged and ageing employees over a follow-up of 12 years.

**METHOD:** The Helsinki Health Study cohort data on 40–60-year old employees of the City of Helsinki, Finland, were used. Surveys were conducted in 2000–02 (response rate 67%), 2007, and 2012 (N=6,131, 82% women). Common mental disorders (CMD) were measured by the General Health Questionnaire (GHQ-12) at all three time points and dichotomized between scores 2 and 3.

**RESULTS:** Prevalence of CMD was 24% at baseline, decreasing to 23% and 21% over the 12-year follow-up. CMD were more prevalent among women than men, but the decrease over the follow-up was similar among both genders. Prevalence of CMD was stable in the younger age-group (40–50 years at baseline) while the older age-group (55–60 years) accounted for most of the decrease (prevalence of CMD 17% in 2012). Age affected the prevalence more than retirement. Examination of CMD severity showed especially large decrease in the prevalence of more severe CMD among women and in the older age-group. Among those with limiting long-term illness at baseline CMD were prevalent and the prevalence declined from 41% to 29% over the follow-up. Marital status had only small effects.

**CONCLUSIONS:** This study identified several factors affecting the mental health trajectories over 12 years among middle-aged employees. Better understanding of these factors helps support the ageing employees' well-being and work ability.

**56781**

### **EDUCATIONAL DIFFERENTIALS IN ANTIDEPRESSANT USE TRAJECTORIES AMONG DEPRESSED INDIVIDUALS**

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**INTRODUCTION:** Although depression is found more common among individuals with low education, some studies find educational differentials in antidepressant use, the principal treatment for depression, to be small or even reversed. This suggests unmet need for depression treatment among those with low education. It is, however, unclear how this lack of treatment occurs; whether it is a question of not seeking treatment, not being offered treatment, or poorer adherence to treatment among people with lower education. We aim to answer these questions by studying educational differences in antidepressant use trajectories before and after hospital treatment for depression.

**METHOD:** We use Finnish individual-level register data on community-living adults in 1998–2007 to assess educational differences in antidepressant purchases in consecutive 3-month periods up to 5 years

before and after hospital care for depression. Any antidepressant purchases (yes/no) and the number of antidepressant doses purchased are assessed in each period.

**RESULTS:** We found no educational differences in antidepressant treatment before hospital care for depression. However after discharge, the number of purchased antidepressant doses was significantly larger among those with higher education. The difference in doses was most pronounced in the first six months after the hospital episode but lasted for up to three years. Educational differences in the likelihood of any antidepressant treatment were negligible.

**CONCLUSIONS:** Our results suggest educational differences in adherence to antidepressant treatment rather than in being offered treatment because any antidepressant use in the acute phase was not related to education, whereas continuous use after the acute phase was.

**56573**

### **PATHWAYS FROM ADOLESCENCE FAMILY RELATIONS TO MID-ADULTHOOD MENTAL HEALTH**

*Noora Berg*<sup>1</sup>

*Olli Kiviruusu*<sup>1</sup>

*Ossi Rahkonen*<sup>2</sup>

*Sakari Karvonen*<sup>1, 2</sup>

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<sup>2</sup> Hjelt Institute, Department of Public Health, University of Helsinki, Finland

<sup>3</sup> City of Vantaa, Finland

**INTRODUCTION:** We examined pathways from problems in family relations in adolescence to mid-adulthood mental health through different life domains in young adulthood.

**METHOD:** Participants of a Finnish cohort study in 1983 at 16 years were followed up using postal questionnaires when aged 22, 32 and 42, (N=1334). Structural equation modeling was used to analyse indirect effects from problems in family relations (e.g poor relationship with mother)(16y) to mental health (Kessler psychological distress scale)(42y) via somatic health, social network, socioeconomic factors and alcohol use (22/32y). First every life domain was analysed separately and then controlling for other indirect paths and covariates. Indirect effects regarding ages 22 and 32, as well as women and men, were analysed separately.

**RESULTS:** When analysed separately paths from problems in family relations in adolescence to mid-adulthood mental health went through somatic symptoms (22/32y) and heavy drinking (32y) and in women also through low employment status (32y). When all the life domains were analysed simultaneously in one model, all the paths remained essentially the same, but the path through heavy drinking (32y) disappeared in men. After adjusting for family structure and psychological symptoms in adolescence, the somatic paths disappear and others attenuate.

**CONCLUSIONS:** Heavy drinking represents a strong pathway from problems in family relations in adolescence to mid-adulthood mental health, but has a unique effect regardless of other paths only in women. Also other adolescence conditions especially mental health explain much of the pathways. Heavy drinking acts as a target for interventions in preventing mental health problems.

**57242**

### **SOCIAL INEQUALITIES IN THE EMERGENCE AND PERSISTENCE OF SLEEPING PROBLEMS IN EUROPE'S OLDER ADULTS**

*Vera van de Straat*

*Piet Bracke*

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**INTRODUCTION:** Although we spend one third of our lives asleep, sociological research concerning sleep and trouble sleeping is fairly limited. In this study we aim to provide more insight into the social inequalities in sleeping problems among Europe's older adults. Using cross-national data we add to the fairly limited literature examining cross-country differences in sleeping problems.

**METHODS:** In order to examine the social determinants of the emergence and persistence of sleeping problems, data from the first (2004/2005), second (2006/2007) and fourth (2011/2012) wave of the Survey



of Health Ageing and Retirement in Europe are used to perform mixed effects logistic regression analyses. Data consists of 10541 individuals aged 50 and older from 10 European countries.

**RESULTS:** In wave 1, sleeping problems are reported by 18,8% of the sample. 54% and 51,4% of them still report sleeping problems in wave 2 and 4 respectively. Women, the lower-educated and people who live alone show to be more likely to report sleeping problems. Only in women the experience of sleeping problems in wave 1 is found to be associated with a higher risk of sleeping problems at follow-up. Additionally, people tend to report more trouble sleeping as they grow older and patterns of sleeping problems show to vary between countries.

**CONCLUSIONS:** Our study shows that sleeping problems are quite common and often persist in the older European population. The determinants of the emergence and persistence of sleeping problems appear to differ, which shows the importance of distinguishing between these two aspects of trouble sleeping. Since there is no clear pattern in the between-country variation, future cross-national research is warranted.

## **Session 1C: SMOKING I**

**Chair: Tomi Mäki-Opas, National Institute for Health and Welfare (THL), Finland**

**56683**

### **INEQUALITIES IN CIGARETTE SMOKING AMONG MEN: EVIDENCE FROM A TOBACCO GROWING COUNTRY IN SUB-SAHARAN AFRICA**

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*Eugene Kofuor*

*Maafo Darteh*

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**INTRODUCTION:** Cigarette smoking is a public health burden in both developed and developing countries and accounts for a large burden of inequalities in morbidity and mortality globally. However, there is still a dearth of nationally representative studies from Sub-Saharan Africa that will unveil the scale of inequalities in the phenomenon and consequently inform cigarette use interventions in the region. Disparities in cigarette smoking were explored among men in Ghanaian, a tobacco growing country in Sub-Saharan Africa.

**METHOD:** A nationally representative sample of Ghanaian men 15–59 years was surveyed in the 2003 (N = 5015) and 2008 (N = 4568) Ghana Demographic and Health Surveys (N = 9583). Logistic regression analyses were conducted to investigate inequalities in cigarette smoking and the changes over the two study periods.

**RESULTS AND CONCLUSIONS:** We found apparent inequalities in cigarette smoking by occupation, labour market position and wealth to the disadvantage of those at the lower end. Similarly, having lower educational attainment increased the likelihood of cigarette smoking. Age, place of residence and religious practice were also related with cigarette smoking among Ghanaian men. Cigarette smoking from 2003 to 2008 revealed that changes in the behaviour over the 5 year period varied by educational attainment, wealth, place of residence and age. Cigarette smoking interventions among Ghanaian men should particularly target lower socioeconomic groups in order to avert an increase in the inequalities in the behaviour and prevent a consequent increase in the socioeconomic gradient in tobacco-related diseases and deaths.

**56103**

### **CULTURAL CAPITAL AND SMOKING IN YOUNG ADULTS: EXPLORING NEW INDICATORS OF SOCIAL INEQUALITIES IN HEALTH**

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**INTRODUCTION:** Associations between education and health behaviours are well documented, but the mechanisms at work are still not well understood. Cultural capital theory may contribute to our understanding of these mechanisms by including individuals' knowledge, skills and beliefs to our

examination of how education may impact on individuals' health lifestyles. We explore the structure and explanatory power of a set of cultural capital indicators in relation to smoking behaviour.

**METHODS:** We analysed data from the Swiss Federal Survey of Adolescents (CH-X) 2010-2011 panel of young Swiss males (n = 10,736). We explored a set of nine theoretically relevant variables (indicating embodied, institutionalized and objectified cultural capital) for their underlying dimensions using exploratory factor analysis. We then ran multiple regression models to test the association between cultural capital factor scores and smoking outcomes. Outcome measures were daily smoking status and number of cigarettes smoked daily.

**RESULTS:** Cultural capital indicators aggregated in a three-factor solution representing "health values", "individual resources" and "family resources". Each factor score predicted both smoking outcomes.

**CONCLUSIONS:** Health values, individual and family based resources emerge as three dimensions that can represent some of the facets of young adults' cultural capital. Scoring low on health values, individual and family resources was associated with a higher risk of being a daily smoker and of smoking more cigarettes in young adults. Cultural capital indicator development is still in its early stages. Our findings build upon its current operationalization and further its measurement, which will contribute to our understanding of the relevant resources that individuals can access and use towards health.

**57305**

### **SMOKING SOCIO-ECONOMIC INEQUALITIES IN SCHOOL-AGED TEENAGERS FROM SIX EUROPEAN COUNTRIES: THE ROLE OF SOCIAL NETWORKS**

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In Western countries, smoking accounts for a large share of health socio-economic inequalities. As smoking initiation occurs around 13 years old, it is likely that social ties at school play influence such inequalities. We present SILNE, a social network survey analysing how social ties at school explain smoking socio-economic inequalities in 6 European cities. It tests two hypotheses: (1) smoking socio-economic inequalities is the result of social ties at school and (2) the contribution of social ties to inequalities is enhanced in a strongly regulated environment. A social network survey was carried out in 2013 in six medium size European Cities having an average income similar to the national average: Namur (Belgium), Tampere (Finland), Hannover (Germany), Latina (Italy), Amersfoort (The Netherlands), Coimbra (Portugal). In each city, 6 to 8 schools were selected. In each school we invited all students from two grades (14-16 years old) to participate to a social network survey. Each student had to nominate up to 5 of his best friends. The survey collected information from 11,041 teenagers in 50 schools from a total of 13,611 registered students, yielding a participation rate of 81%. The sample had an average age of 15.2 and was 51.8% female. 17% were current smokers and started smoking at 13.3, and score 5.5 and the nicotine dependence scale. On average, a teenager nominated 3.3 friends. Friendship ties with teenagers of the same-socio-economic background and of the same smoking status were more likely to occur. Smoking inequalities were reduced when controlling for the social network exposition to smoking (the closeness of smokers). We found evidence that such network effect is vulnerable to the school context. The SILNE survey provides an new perspective on health inequalities. It opens avenues for new interventions based on sociological theory.

**57114**

### **ELECTRONIC CIGARETTES AND THE USE OF TOBACCO PRODUCTS AND NICOTINE REPLACEMENT THERAPY: A POPULATION-BASED STUDY**

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*Hanna Ollila*

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**INTRODUCTION:** Electronic cigarettes (e-cigarettes) are gaining popularity in Western world. E-cigarettes are often marketed for smokers as an aid for smoking cessation. This study shows the associations of e-cigarette use and the use of tobacco products - cigarettes and snus - and nicotine replacement therapy (NRT).

**METHODS:** Quantitative analysis of cross-sectional population-based study of Finnish adults (N=5146) aged 15–64 years in 2012–2013. Tests used: chi-square-test and binary logistic regression.

**RESULTS:** E-cigarette use was low in Finland on population level (1,9 %). 15–24-year-olds used e-cigarettes more often than older respondents. The use of e-cigarettes was independent of gender or education level. 13 % of current smokers used e-cigarettes, but among quitters (0,8 %) and non-smokers (0,3 %) the use was very low. Wanting to quit smoking was more common among e-cigarette users than among non-users (44 % vs. 34 %), as was previous use of NRT for cessation support (31 % vs. 13 %). In regression models non-smokers had lower risk for e-cigarette use than current or former smokers. Occasional use of snus and young age were also associated with e-cigarette use. Among daily smokers prior use of NRT and higher amount of cigarettes per day were associated with e-cigarette use. Interest in quitting smoking did not predict e-cigarette use.

**CONCLUSIONS:** The use of e-cigarettes is associated with the use of tobacco products. Further, it is not clear whether e-cigarettes serve purely for smoking cessation purposes or as a product for parallel use alongside tobacco products.

## **Session 1D: INEQUALITIES IN SELF-RATED HEALTH**

**Chair:** Olaf von dem Knesebeck, University of Hamburg, Germany

**56977**

### **SOCIAL INEQUALITIES IN SELF-RATED HEALTH IN UKRAINE**

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**INTRODUCTION:** Despite Ukraine's diversity and large population size, few studies have examined social inequalities in health. This study aims to describe the patterning of health inequalities in Ukraine by a range of socio-economic circumstances and to examine to what extent health behaviours account for any relationships.

**METHOD:** The data are 1209 men and 915 women from the 2007 wave of the Ukrainian Longitudinal Monitoring Survey. In logistic regressions of complete cases stratified by gender, declaring poor or very poor health was regressed on education, household income, material assets and labour market status before and after inclusion of measures of health behaviour, including smoking, alcohol use and exercise.

**RESULTS:** Education level was not associated with poor or very poor health in either gender. Lower household income and fewer assets were associated with self-rated health in bivariate analyses in both genders. In multivariate modelling simultaneously including all measures of socio-economic position and demographic characteristics, these associations were no longer significant, with the exception of household income in the male sample. In men, being unemployed was associated with greater risk of poor or very poor health, as was declaring being of pensionable age, compared to men in paid work. Labour market status was not associated with health in women. Exercise, smoking and alcohol use mediated the relationships between self-rated health and the measures of socio-economic position little or not at all.

**CONCLUSIONS:** This study suggests that upstream determinants of health, such as joblessness and poverty, affect health independently of individual health behaviours.

**57096**

### **ECOLOGICAL STUDY OF RELATIONSHIP BETWEEN SELF-RATED HEALTH AND INCOME INEQUALITIES IN JAPANESE DISASTER AREA**

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**INTRODUCTION:** In social determinants of health researches, income inequalities is important societal factors for health. Japanese have suffered from economic recession for a long time. Then, it is important to reveal the determinants of health from the socioeconomic perspectives. In this situation, Japanese experienced the Great East Japan Earthquake (March 11, 2011). The earthquake brought serious damage on socioeconomics and health. Considering the situation, income inequalities in areas damaged by the earthquake might be associated with health problems. Therefore, this study aims to reveal the relationship between self-rated health and income inequalities before and after the earthquake.

**METHODS:** I conducted repeated cross-sectional survey. First wave was conducted in February 2011. Subjects, who were 20-74 years old, were residents of eleven municipalities in Miyagi prefecture. 499 answers were obtained (61% response rate). Second wave was conducted in November 2012. 2318 answers were obtained (64%). Outcome variable was self-rated health (SRH), calculated proportion of mal health for each municipalities. Explanatory variable was income inequalities, calculated Gini coefficient by household income for each municipalities. I conducted regional correlation analysis with these two variables.

**RESULTS:** SRH and Gini coefficient differed by municipalities. SRH tended to be worse than before the earthquake. According to correlation analysis, I could not observe a significant correlation between Gini coefficient and SRH in 2011. However, I could find the relation in 2012 clearer than in 2011.

**CONCLUSIONS:** This study indicated income inequalities related to health after the Great East Japan Earthquake, although the relation could not observe before the earthquake. Because health and income inequalities worsened in damaged area, we could find the relation between income inequalities and health after the earthquake. It suggests it is important to devise socioeconomic policy intervention that is tailored to local needs. Acknowledgement: This work was supported by SFR and KAKENHI.

**56766**

### **SOCIAL INEQUALITIES IN PATIENT-REPORTED OUTCOMES AMONG OLDER MULTIMORBID PATIENTS**

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*Hendrik van den Bussche*

*Ingmar Schäfer*

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In the analyses three research questions are addressed: (1) Is there an association between socioeconomic status (SES) and patient-reported outcomes in a cohort of multimorbid patients? (2) Does the association vary according to SES indicator used (income, education, occupational position)? (3) Can the association be (partly) explained by burden of disease? Analyses are based on the MultiCare Cohort Study, a German multicentre, prospective, observational cohort study of multimorbid patients from general practice. We analyzed baseline data and data from the first follow-up after 15 months (N=2,729). To assess burden of disease we used the patients' morbidity data from standardized general practitioner (GP) interviews based on a list of 46 groups of chronic conditions including the GP's severity rating of each chronic condition ranging from marginal to very severe. We focused on the patient-reported outcomes self-rated health, health-related quality of life and functional status. Analyses reveal that only income (but not education and occupational position) was significantly related to the patient-reported outcomes at follow-up. Associations between income and the outcomes were reduced by 18% to 27% after adjustment for burden of disease. Results indicate social inequalities in self-rated health, functional status and health related quality of life among older multimorbid patients. As associations with education and occupational position were inconsistent, these inequalities were mainly due to income. Inequalities were partly explained by burden of disease. However, even among patients with a similar disease burden, those with a low income were worse off in terms of the three patient-reported outcomes under study.

**55498**

### **SOCIAL RELATIONS AND HEALTH IN BELARUS**

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**INTRODUCTION:** The pathways between social capital and health are still insufficiently researched especially in Eastern Europe. This study aims at investigating the impact of social participation and close relations on self-rated health in Belarus.

**METHODS:** The material of the study was collected in the context of a national health survey in Belarus in 2012. It consists of a representative nation-wide sample of more than 2000 persons, who were interviewed about their health and social circumstances, amongst other themes. Investigating the co-variation between the experienced quality of different social relations, it appeared that it was similar for different kinds of relations, and it was treated as one variable. Regression analyses were used to investigate the effects of the independent variables.

**RESULTS:** In consecutive regression analyses it was found that while age exerted the strongest (negative) effect on self-rated health among both men and women, the (positive) impact of education was overshadowed by the likewise positive effect of the general quality of one's social relations. However, while the perceived quality of the relations did influence health moderately, the frequency of different types of social contacts did not have any influence. Moreover, when the types of social relations were taken separately it appeared that men's health is consistently most influenced by the quality of familial relations, while the effect of the relations to peers/workmates on women's health is at least as strong. Regional differences in health (notably the positive effects of living in Minsk City and Brest oblast) disappeared when controlled.

**CONCLUSIONS:** Similar to some previous studies, men's health was more positively influenced than women's by their familial relations. The quality of the relations outside home was, however, more important for women's health. Notable was also that the quality of different relations tended to covary positively.

## **Session 1E: DISEASE CAREERS I**

**Chair:** Sara Arber, University of Surrey, UK

**59352**

### **IMPACT OF SOCIAL CAPITAL ON HEALTH AND WELL-BEING AFTER A CANCER DIAGNOSIS**

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**INTRODUCTION:** Incidence of cancer diseases is rising in developed countries, but early diagnosis and effective treatment have led to good prognoses: people live long after a cancer diagnosis. Today, most patients have seldom contacts to the health care system after the primary treatment, and recovery rely on the patients' resources. Social capital is a personal resource that includes social networks (e.g., access to information and support), social participation, and trust. Social capital is associated with health; we investigate its association with well-being after cancer diagnosis.

**METHODS:** In consecutive samples of 225 breast cancer, 120 prostate cancer, and 70 lymphoma patients who entered Oulu University Hospital, oncology, we measured social capital (cancer-specific social networks, interpersonal trust, reciprocity, participation), other health determinants, and aspects of well-being (e.g., health-related quality of life) with validated questionnaires 3–5 months after the diagnosis. The measurement was repeated and the use of health care services tracked up to five years. We investigate elements of social capital and its impact on the patients' well-being. The breast cancer cross sectional data has been finalized.

**RESULTS:** The elements of social capital associated with each other and the well-being measures. Especially interpersonal trust predicted most well-being dimensions, despite adjusting for other health variables. Informal social networks and number of health care professionals associated with the well-being. Number of acquaintances the patient has discussed the cancer predicted a better well-being, while number of doctors associated with more symptoms.

**CONCLUSIONS:** Social capital predicts health after cancer diagnosis. As suggested earlier, interpersonal trust demonstrates an independent association with health. Cancer-specific social networks associate with well-being.



59423

**INEQUALITIES IN POST CANCER SOCIAL REHABILITATION: A QUALITATIVE STUDY AMONG YOUNG WOMEN WITH BREAST CANCER**

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**INTRODUCTION:** "Life After Cancer" is one of the priority themes of the French Cancer Plan 2014-2019. This study aims to specifically assess the influence of the hospital organization on the perceptions and the strategies for social rehabilitation developed by the patients. The second objective is to obtain more detailed understanding of the processes leading to disparities in the use of programmes to assist rehabilitation. **METHODS:** A socio-anthropological study has been conducted in two comprehensive cancer centres among 36 women aged 50 years or less; treated for non metastatic breast cancer and having completed the hospital care procedures since at least 6 months and within less than 2 years. Two complementary methods of investigation have been used: semi-structured individual interviews (70%) and focus-group interviews (30%).

**RESULTS:** Data were analyzed in to 2 thematic axes: - The problems of the post-care and strategies used by the patients - Knowledge and use of hospital support Our study shows that the most vulnerable population with a low level of education is very impacted on two points: the impact of cancer on professional trajectory work and the difficulties to identify hospital support and to use them.

**CONCLUSIONS:** This study may lead to a review of the goals and tools used in hospital to guide patients who require support toward hospital resources.

57153

**SOCIAL PATTERNING OF RECOVERY FROM PHYSICAL ILLNESS: PATIENTS' EXPERIENCES OF HEART ATTACK AND LEUKAEMIA**

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**INTRODUCTION:** Comparatively little attention has been paid to the social dimensions and social patterning of recovery from major physical illness. Bourdieu's concept of social capital, residing in the social networks of individuals, has retained value (Carpiano 2006) despite questions over the usefulness of measures of community level social capital in explaining health inequalities (Dahl and Malmberg-Heimonen 2010).

**METHOD:** This paper presents a secondary analysis of qualitative interview data collected by the Health Experiences Research Group, University of Oxford. Forty-four adults who had experienced a heart attack and 39 patients who had been diagnosed with leukaemia were interviewed about their experiences. A thematic analytical approach was employed.

**RESULTS:** Support provided by partners differed from that of other family members or friends. Personal cultural capital and bridging forms of social capital, located in patients' occupational background and social networks, were evident in their accounts of interactions with health professionals. Loss of income through illness was mitigated by both personal and family economic resources and proximity to retirement. Two key differences between the datasets were noted: emotional support and bridging social capital conferred by a heart attack rehabilitation programme; and differences in experiences of acute versus chronic forms of leukaemia.

**CONCLUSIONS:** Experiences of recovery from heart attack and leukaemia appear socially patterned in respect of partnership status and dimensions of cultural and social capital. This study demonstrates the utility of the concept of individual social capital, in both bonding and bridging forms, for exploring social patterning in experiences of illness and recovery.

59384

**MORAL OBLIGATIONS AND EXPECTATIONS OF ADULT SURVIVORS OF CHILDHOOD LIVER TRANSPLANT: DESERVING OR UNDESERVING RECIPIENTS?**

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**INTRODUCTION:** The implicit relationship in organ transplantation assumes that recipients should behave in ways that take care of the donor organ as a way of acknowledging the benefactor's act. This normative assumption renders recipients deserving or undeserving after they have had a transplant. In particular these issues are often the focus for moral controversy regarding who should be deemed suitable for liver transplantation; alcohol abusers with liver disease often being viewed as unsuitable recipients. However, discussions regarding issues of moral obligations and expectations have to date focused on adult transplant recipients. 'New' ageing populations - adults growing older with diseases conventionally associated with childhood - create a new terrain for discourses of moral desert as well as moral expectations.

**METHOD:** We explored these normative moral issues through 27 in-depth interviews with members of the first UK cohort of childhood liver transplant recipients, who underwent surgery up to 30 years ago, and are now in their 20s and 30s.

**RESULTS:** Control and responsibility for a donor liver ran clearly through all accounts. However, this was set against notions of current youth culture, with ambivalence arising from the perceived social acceptability of alcohol consumption for this age group and uncertainty from the medical profession as to whether alcohol was harmful for these recipients.

**CONCLUSIONS:** Recipients, professionals and families continue to negotiate what is both individually and socially appropriate in terms of behaviour. We find that conventional discourses of deserving and undeserving recipients remain resonant, with no counter-discourse as yet available to them.

**Session 1F: PROFESSIONS I**

**Chair:** Jon Ivar Elstad, NOVA, Oslo and Akershus University College, Norway

57216

**GOING OVER TO THE "DARK SIDE"? THE VULNERABILITY OF MEDICS WHO MANAGE**

*Ellen Annandale*

University of York, UK

**INTRODUCTION:** When we think of medical consultants, the image evoked is likely to be one of power, and, indeed, this typically is how they are perceived by other staff in healthcare organisations. In this paper we turn the tables and inquire how consultants themselves perceive their position. In particular, we examine how medical consultants, who also perform managerial functions, reflect upon their interactions with peers and uncover the hitherto unexplored vulnerabilities of the hybrid clinician-manager role.

**METHOD:** Our analysis draws on in-depth interviews with a range of managers (91 in total) in two large English NHS hospitals (undertaken between 2010 and 2012).

**RESULTS AND CONCLUSIONS:** Consultant-managers spoke of the precariousness of their position: they described themselves metaphorically as being "suspended" or "hovering" over a pool of their erstwhile peers - the pool into which they were likely to "drop back" into when their term as managers were over. Some also reported that their identity had been tainted and their credibility undermined as a result of having "gone over to the dark side" (i.e. joining the managerial ranks). They perceived their authority to be severely limited by their inability to impose any sanctions on their peers, who would jeeringly reply "Well, make me" to the clinician-managers' requests. We explore how these vulnerabilities generated the challenges that consultant managers experienced in managing their peers. We also examine the strategies that consultant clinical managers employed to counter these vulnerabilities, such as espousing an organisation-wide vision and drawing on their wider management team (of general managers and senior nurses) to counterbalance the force of consultant peers in order to get their managerial work done. This experience is compared to the contrasting role of the senior nurse clinician-manager.

56757

### **SOCIAL INEQUALITIES IN HEALTH-RELATED BEHAVIOURS PROMOTED BY FRENCH GENERAL PRACTITIONERS**

*Laurent Rigal<sup>1</sup>*

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To avoid increasing and if possible to reduce social inequalities in health, GP are supposed to promote HRB to everyone with equity. Our aim was to compare social inequalities (1) in patients' HRB and (2) in GPs' practices promoting the adoption of these HRB by their patients. Fifty-two GPs from two Parisian universities volunteered to participate. Each of them included 70 patients (35 women and 35 men) between 40 and 74 years randomly drawn among their registered patients. Patients' social characteristics (occupation, education and perceived financial situation) and HRB (tobacco and alcohol consumption, diet and exercise, cancer screening) were collected from the patients by postal questionnaires. GPs practices extracted from medical records were consumer status and the identification of consumers for tobacco and alcohol, diet and exercise counselling and date of completion for cancer screening. Social inequalities in HRB and in GP's practices were analysed with mixed models, stratified by sex and adjusted for age and primary care utilisation. Among the 2599 patients enrolled (participation rate 71%), the largest inequalities in HRB were observed for cervical cancer screening (OR between workers and managers =7.49, 95%CI=2.00-28.04), which were superimposed to a poorer recording of the date of completion at the bottom of the social hierarchy (OR=0.28, 95%CI=0.09-0.80). At the opposite, social inequalities in excessive alcohol consumption were associated with a better identification of consumers from the bottom of the social hierarchy. GPs practices are not always in favour of a reduction of the social inequalities in HRB observed among their patients.

55946

### **HOW SOCIAL TIES INFLUENCE PATIENT'S CHOICE AND THEIR RELATIONSHIPS WITH HEALTH PROFESSIONALS**

*Abdou Senghor*

LISST-CERS, France

**INTRODUCTION:** The patient's well-being depends on his consent to treatment proposed by treatment providers and also his personal choice of dialysis treatment. Hence, the patient is a key decision-maker in his medical care. As part of our research, we wanted to determine the factors influencing patient choice and his medical decisions.

**METHOD:** We observed a therapeutic education programme and conducted interviews with nephrologists, educators and patients (including Hemodialysis and Peritoneal dialysis patients). Two types of patients were included: participants and non-participants in the therapeutic education programme. These interviews were analyzed using the inductive method.

**RESULTS AND CONCLUSIONS:** Our findings showed that the social ties between patient and family as well as patient and medical care providers, affect decision-making leading to either difficult negotiations or easy patient's consent, facilitation of strategies for medical empowerment, or delayed negotiations. Patients trusted lay knowledge gained anecdotally from their social network. The first meetings of the patient with treatment providers can generate greater trust when patient preferences are taken into account. But the further the patient progresses in his treatment, the weaker this trust becomes. In the event that the patient maintains trust in his physician, the patient chooses to depend on him. This dependence creates what is known as caused paternalism. Shared decision-making does not preclude medical paternalism.

57195

### **CARDIOVASCULAR RISK PATIENTS: CLINICAL STRATEGIES, PATIENTS' STRATEGIES**

*Beatriz Xavier*

Nursing School Coimbra, New Lisbon University, Portugal

**INTRODUCTION:** Physicians prescribe cardiovascular risk patients with a system for body care which is mainly based on a regulated diet, physical exercise and pharmacological therapy. Although understood,



medical argumentation is shaped by different daily routines and rationalities. Body adjustment occurs at several levels: daily life, consultation, self-control, medical control. The demand for discipline and rules of conduct is constantly questioned and negotiated in patients' practices.

**METHOD:** The aim of the study was understand how clinical disease control is associated with normal routines. Forty-one interviews were performed to hypertensive patients enrolled in a specific blood pressure consultation. Six consultations were directly observed. A qualitative methodological approach was adopted.

**RESULTS:** Interviews and consultation observation revealed different body perceptions, a pragmatic attitude of patients towards consultation, life hygiene measures and pharmacological therapy. The preventive model exalts individual accountability, assuming the presence of contemporary patient for whom the physician would be a supervisor. However, neither consultations nor patients' narratives reveal this. Consultations are not used by patients to reinforce their autonomy but to place the responsibility for establishing control and monitoring on the physician. Being assertive with the indications and observation of the data submitted by the clinician, patients always set such situations within their daily occurrences and contexts. Medication plays a central role in consultation.

**CONCLUSIONS:** Weight changes and blood pressure readings are not autonomous realities, separable from contexts. We consider rationality as purpose as the only valid form of rationality but another form is possible, rationality as value, which consists of a disjunction between behaviour and consequences by reference to a system of values and principles. The actions of hypertensive patients are not only expressed in terms of rationality purpose. It is above all the truth by experience that lets them set out actions and provisions for future behaviour and justifies them.

## **PARALLEL SESSIONS II**

**THURSDAY 28 August at 13.30 - 15.00**

**Session 2A: HEALTH CARE I, pre-organized session: Health care systems and health inequalities 1**

**Organizer and chair: Simona Olivadoti and Mara Tognetti Bordogna, University of Milan-Bicocca, Faculty of Sociology, Italy**

**57038**

### **EDUCATIONAL DIFFERENCES IN MORTALITY AMENABLE TO HEALTH CARE BETWEEN HEALTH SYSTEMS**

*Erlend Løvø Fjær*<sup>1</sup>

*Terje Andreas Eikemo*<sup>1, 2</sup>

*Tim Huijts*<sup>3, 4</sup>

*Ivana Kulhanova*<sup>1</sup>

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<sup>2</sup> Department of Sociology and Political Science, Norwegian University of Science and Technology, Norway

<sup>3</sup> Department of Sociology, Utrecht University/ICS, The Netherlands

<sup>4</sup> Department of Sociology, University of Oxford, UK

**INTRODUCTION:** The aim of this study is twofold. First, we ask to what extent the strength of educational differences in mortality amenable to health care vary across European countries. Second, we examine to what extent these cross-national variations can be explained by differences in European health system types.

**METHODS:** This study uses mortality data for 21 European populations. People aged 30–74 years are included in the analysis. Educational attainment is coded according to the International Standard of Education. Educational inequalities in mortality amenable to health care across health care systems are calculated by relative indices of inequality (RII) by means of Poisson regression. The article categorizes health systems based on expenditure, financing, service provision and access regulation, resulting in three different health systems: the health service provision-oriented type, the universal coverage – controlled access type and the low budget – restricted access type.

**RESULTS:** Preliminary results show that educational inequalities amenable to health care are relatively large in the universal coverage health system.

**CONCLUSIONS:** The educational differences in amenable mortality for European countries indicate an important role for health care systems in reducing inequalities in health. Future research should aim at examining the role of specific characteristics of health systems in more detail.

**59244**

**PUBLIC EXPENDITURE AND SOCIOECONOMIC DISPARITIES IN INFLUENZA VACCINATION ACROSS EUROPE**

*Johanna Bristle*

MEA - Max Planck Institute for Social Law and Social Policy, Munich, Germany

**INTRODUCTION:** The elderly population is at high risk for influenza deaths. Therefore, influenza vaccination uptake (IVU) is highly recommended by health experts. The literature regarding socioeconomic disparities in IVU is mixed and cross-country comparison is rare. This paper investigates socioeconomic disparities in IVU and explores the variation across countries. The main focus of the paper will be on the influence of institutional characteristics of the respective health care systems on IVU and the social gradient herein. Due to the increasing privatization of health care, individuals' scope of action and self-responsibility are increasing. Without health policy regulation, this trend leads to larger socioeconomic disparities.

**METHODS:** Data comes from the Survey of Health, Ageing and Retirement in Europe (SHARE). The sample consists of individuals over 65 years from 13 countries. For institutional influences, OECD data on public expenditure of prevention and public health and an indicator if the vaccination is free of charge or not are used. Pooled logit models analyse the influence of socioeconomic variables as well as the interaction of them with institutional characteristics. Predicted probabilities and marginal effects are presented graphically.

**RESULTS:** The preliminary results show that in the population 65+ IVU varies across countries between 10-78% and also between lower and higher socioeconomic groups. Regarding institutional characteristics, countries with higher expenditure on prevention and public health have higher vaccination rates, however, this association holds for both education groups similarly (no interaction effect). Similarly, providing vaccination free of charge increases the probability of IVU, but this effect does not vary by income groups.

**CONCLUSIONS:** Public expenditure is associated with the likelihood to get vaccinated against influenza, but does not address the socioeconomic gap in influenza vaccination uptake.

**Session 2B: MENTAL HEALTH II**

**Chair:** Heta Moustgaard, University of Helsinki, Finland

**59069**

**KNOWLEDGE RELATIONS IN PSYCHOTHERAPY INTERACTION**

*Elina Weiste*

*Liisa Voutilainen*

Finnish Centre of Excellence in Research on Intersubjectivity in Interaction, University of Helsinki, Finland

**INTRODUCTION:** Knowledge relation has been in interest of medical sociology for several decades. In psychotherapy interaction two types of specific knowledge need to be shared: clients' knowledge of their personal experiences and therapists' professional knowledge of human mind. However, how is the therapist to integrate these knowledge types and gain access to the client's private experiences? This research explores the interactional practices that therapists use for interpreting clients' inner experiences.

**METHOD:** 70 audio-recorded sessions of cognitive psychotherapy and psychoanalysis were analysed using Conversation Analysis.

**RESULTS:** Three different practices the therapists use for delivering their interpretations were identified 1) "reflective interpretations" in which the therapists communicated their understanding of the clients' experiences that were implied but not stated by the clients, 2) "hypothetical interpretations" in which the therapists clarified the clients' experiences by tentatively offering new information of the client's experience and 3) "instructive interpretations" in which the therapists offered an alternative account to the

client in order that the client would understand the patterns or connections they did not see before. Knowledge relations in these practices were different and they affected on clients' ability to provide an elaborated response. Psychoanalysis and cognitive psychotherapy differed in the kind of knowledge claims the therapists used and how the access to the clients' mind was gained.

**CONCLUSIONS:** The practices that focus on clients' inner experiences are a fingerprint of psychotherapy as institutional interaction. Therapists cannot establish their knowledge claims only on their professional expertise but several kinds of interactional work is needed to justify their claims.

**59650**

### **DEALING WITH STIGMA OF MENTAL ILLNESS - VISUAL ANALYSIS OF CHINESE AND EUROPEAN SOCIAL CAMPAIGNS**

*Anna Prokop<sup>1</sup>*

*Natalia Ozegalska-Lukasik<sup>2</sup>*

<sup>1</sup>Department of Medical Sociology, Chair of Epidemiology and Preventive Medicine, Jagiellonian University Medical College, Poland

<sup>2</sup>Institute of Sociology, Jagiellonian University, Poland

Mental illnesses are one of the most stigmatizing conditions in the majority of the contemporary societies. Cultural discrepancy delivers diverse contexts for labeling, discrimination and exclusion of individuals due to their mental health problems. The presented study addresses a question of differences in tackling stigma of mental illness with instruments of social marketing in Europe and China. In the framework of comparative visual analysis several types of visual materials of the national and local anti-stigma campaigns from three European countries and China were studied. The analysis included verifying visual means and strategies, used to convey anti-stigma message. The studied material demonstrated significant differences in narratives and means of expression between European and Chinese campaigns. The former focused on stigma experienced by individuals, while the later mainly stressed courtesy stigma challenged by family members. The major dissimilarities were interpreted in reference to the cultural dimension of individualism vs. collectivism.

**56927**

### **BEING CHRONICALLY ILL: THE SOCIALLY AND RELATIONALLY STRUCTURED INFLUENCES ON WELL-BEING**

*Josephine Foubert<sup>1</sup>*

*Ronan Van Rossem<sup>1</sup>*

*Katia Levecque<sup>2</sup>*

<sup>1</sup>Department of Sociology, University of Ghent, Belgium

<sup>2</sup>Department of Personnel Management, Work & Organizational Psychology, Ghent University, Belgium

**INTRODUCTION:** Despite the evidence of the reduced well-being of people with a chronic illness or impairment compared to people without one, a big challenge remains how to explain this inequality. To get more insight, we approach disability as a process of social exclusion, resulting in a reduced well-being for people with impairments and chronic illnesses. It acknowledges that chronic illnesses affect well-being, but that disability only stems from socially reinforced restrictions. This paper examines if the influence from a chronic illness on the well-being is dependent on socioeconomic position and familial status.

**METHODS:** The European Quality of Life Survey (2012) is used to examine our research questions with multilevel regression techniques. It allows us to identify people with longstanding physical or mental health problems or impairments. Well-being is measured by the WHO Five Well-Being Index. Several indicators of socioeconomic and familial status are included.

**RESULTS:** People with a longstanding illness or impairment have a reduced well-being compared to people without one. The negative effect of having a chronic illness or impairment is different for distinct socioeconomic groups. A higher education, income and working seem to alleviate the negative effect. Same applies to being married and living in a non-deprived dwelling.

**CONCLUSIONS:** The detrimental effects of a chronic illness for the well-being are not equally distributed across society. This is in line with structural theories of health inequalities saying that groups in lower

positions in social hierarchies have a poorer well-being, as they lack fundamental resources to cope with their condition.

## **Session 2C: SMOKING II, pre-organized symposium: Tobacco-free Finland 2040: Equal opportunities for tobacco-free life?**

**Organizer and chair: Jaakko Kaprio, University of Helsinki, Finland**

**54664**

### **SOCIO-ECONOMIC DIFFERENCES IN SMOKING INITIATION IN FINLAND**

*Arja Rimpelä<sup>1</sup>*

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<sup>4</sup> Department of Population and Health, University of Cape Coast, Ghana

**INTRODUCTION:** The origin of socioeconomic health differences is in childhood and adolescence where health compromising behaviours like smoking are adopted. Changes in the relationship of smoking and socioeconomic factors are studied from 1979 to 2013 among adolescents using one's own position (school performance/track) and parents' education. The relation of child smoking with parents' and grandparents' education is studied longitudinally by linking survey and Statistics Finland data.

**METHODS:** The Adolescent Health and Lifestyle Survey (AHLS) were gathered every second year (1977 to 2013) from 12 to 18-year-olds (n= 2932-8390, response rate 88%-44%). AHLS data from 1979 to 1997 (n=62529 respondents) were linked with personal socio-economic data (1970 to 2010) from Statistics Finland concerning the respondents, their parents and grandparents. The definition of a smoker was: 12-14-year-olds, smoked more than 1 cigarette; 16-18-year-olds, smokes daily.

**RESULTS:** School achievement (12-14-year-olds) and school track (16-18-year-olds) were strongly related to smoking: the poorer the achievement/track the higher the smoking rate. Among 12-14-year-olds the differences somewhat widened while among 16-18-year-olds they stayed approximately the same from 1977 to 2013. Adolescent smoking was negatively related to both parents' education, so that the lower the education the higher the child's smoking rate. Girls' smoking was negatively related to both grandmothers' education, and boys' smoking to education of father-side grandparents. Smoking in adolescence predicted lower education in adulthood.

**CONCLUSIONS:** Socioeconomic differences in smoking initiation have stayed rather strong nearly over four decades. Socioeconomic factors of the family affect children's smoking over generations and smoking initiation in adolescence predicts lower adult socioeconomic positions.

**57179**

### **SOCIOECONOMIC DIFFERENCES IN SMOKING CESSATION: 11 YEAR FOLLOW-UP FROM HEALTH2000**

*Ari Haukkala<sup>1</sup>*

*Otto Ruokolainen<sup>2</sup>*

*Hanna Ollila<sup>2</sup>*

*Patrick Sandström<sup>2</sup>*

*Tommi Härkänen<sup>2</sup>*

*Antero Heloma<sup>2</sup>*

<sup>1</sup> Department of Social Research, University of Helsinki, Finland

<sup>2</sup> National Institute for Health and Welfare, Helsinki, Finland

**INTRODUCTION:** Smoking have a major influence on socioeconomic (SES) differences in mortality among men and its effect is increasing among women. Those with low school achievement are more likely to start smoking and smoking prevalence is higher among vocational students than high school students.

Lower educated smokers are more addicted than higher educated smokers. The aim of this study is to examine if there is a difference in smoking cessation in adult population in 11-year follow-up study.

**METHOD:** Finnish population-based cohort study, the Health 2000 survey, was conducted in 2000-2001 and included 8028 subjects (aged  $\geq 30$ ) from all areas of Finland. 73% of the baseline subjects participated to the follow-up survey in 2011. Smoking status and education were self-reported.

**RESULTS:** The prevalence of daily smokers was 23% at the baseline (n=1360) and 30% of these smokers had quit smoking by 2011. Smokers in the tertile with highest education were more likely [OR=1.78 (1.07 – 2.98)] to quit smoking compared to lowest education tertile. Females were as likely to quit smoking as men and there were no interaction effect between gender and education on smoking cessation (p=0.356).

**CONCLUSIONS:** Our result suggests that the differences in smoking between educational groups are increasing. Therefore the SES differences in cessation must be addressed to diminish the differences in morbidity and mortality between SES groups.

**58675**

### **THE CHANGING CONTRIBUTION OF HARMFUL CONSUMPTION OF ALCOHOL AND SMOKING TO INCOME DIFFERENCES IN LIFE-EXPECTANCY**

*Pekka Martikainen<sup>1</sup>*

*Pia Mäkelä<sup>2</sup>*

*Riina Peltonen<sup>1</sup>*

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<sup>3</sup> Max Planck Institute for Demographic Research, Rostock, Germany

**INTRODUCTION:** Social differences in mortality have increased in high income countries, but the causes of these changes remain unclear. We quantify the contribution of alcohol and smoking to trends in income differences in life expectancy in 1988-2007 in Finland.

**METHOD:** An 11% sample from the population registration data of Finns aged 25 and older linked with an 80% oversample of death records. Alcohol-attributable mortality was based on underlying and contributory causes of death on individual death certificates, and smoking-attributable mortality on an indirect method that used lung cancer mortality as an indicator for the impact of smoking on mortality.

**RESULTS:** Alcohol and smoking-attributable deaths reduced life expectancy by about 4.5 years among men. Alcohol-attributable mortality increased and smoking-attributable mortality decreased over the period 1988-2007 leaving the joint contribution stable. Among women the contribution of these risk factors to life expectancy increased from 0.7 to 1.2 years. In 2003-2007 life expectancy differentials between the lowest and highest income quintile were 11.4 years (men) and 6.3 years (women). In the absence of alcohol and smoking these differences would have been 60% and 36% smaller respectively. Life expectancy differentials increased rapidly over the study period; without alcohol and smoking the increase would have been 69% smaller among men and 85% among women.

**CONCLUSIONS:** Alcohol and smoking have a major influence on income differences in mortality and - with the exception of smoking among men - their contribution is increasing. Without alcohol and smoking the increase in life expectancy differentials would have been mostly avoided.



59163

## **SMOKERS WITH MENTAL DISORDERS – AN UNDERSERVED POPULATION IN TOBACCO-FREE INITIATIVES**

*Taru Kinnunen*<sup>1</sup>

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Although smoking prevalence is decreasing in the general population in many countries, smoking prevalence remains high among those with psychiatric illnesses. Smokers with mental disorders also smoke more, are more dependent and are thus especially vulnerable to tobacco-related diseases. There are various neurological and behavioral mechanisms linking smoking and mental disorders. The association between smoking and mental disorders is complex and not yet fully understood. There is evidence supporting acutely reduced psychiatric symptoms, such as anxiety, after smoking a cigarette. There is also evidence for smoking as a risk factor in the etiology of mental disorders. Furthermore, evidence exists of common genetic determinants of smoking and mental disorders, particularly depression and schizophrenia. Smokers with mental disorders are not less motivated to quit than those in the general population. Successful smoking cessation is associated with reduced depression and anxiety and increased positive mood compared with continuing to smoke. Interestingly, the effect size of various treatments for smoking abstinence is nearly as large for those with psychiatric disorders as those without. Unfortunately, only a minority of smokers with mental disorders receive effective tobacco dependence treatment. This disparity in treatment offered causes significant reduction in both quality of life and life expectancy. These findings call for radical changes in the attitudes and dealing with this major cause of premature death and disability in people with mental disorders. Smokers with mental disorders should be considered as an underserved population, which needs urgent attention in tobacco-free initiatives.

## **Session 2D: GENDER AND HEALTH I**

**Chair:** Claudine Burton-Jeangros, University of Geneva, Department of Sociology, Switzerland

56586

## **FATHERHOOD, MOTHERHOOD, GENDER, ‘SHARING’ AND WELLBEING, IN ENGLAND**

*Bob Williams*

Kings College London, UK

**INTRODUCTION:** The wellbeing of mothers and fathers is interdependent but some fathers can be ‘risks or resources’ within families (Scourfield, 2010). This paper reports on a qualitative research study examining the implications of gendered ‘sharing’ for fathers’ and mothers’ wellbeing during pregnancy and the first year of a child’s life.

**METHODS:** A qualitative study was undertaken with a purposive sample of 14 couples, of differing ethnicities and social class backgrounds, within families with infants, in a Midlands city in England. Analysis of mothers’ and fathers’ accounts indicated that a key recurring theme was ‘gendered sharing and wellbeing’.

**RESULTS:** The meaning of ‘sharing’, for mothers and fathers, involved degrees of reciprocity regarding aspects of child rearing, emotional work, intellectual labour (e.g. decision making and planning), domestic labour, paid labour but also presence and absence within the home. ‘Sharing’ was highly valued in dealing, as a couple, with the multiple stresses and strains of pregnancy and child rearing. However accounts were also contradictory: mothers and fathers drew upon differing conceptions of masculinities and femininities to understand the implications these practices have for wellbeing (e.g. autonomy, esteem, support, emotionality, self development) and the extent to which these practices were equitable.



**CONCLUSIONS:** The gendered ‘sharing’ and wellbeing has implications for health and social care policy and practice priorities, including improving the wellbeing of mothers and fathers, engaging fathers, child rearing, childcare and paid work.

**59353**

**“THE RUSSIAN SEX”: PROBLEMS, TRENDS AND PERSPECTIVES IN CONTEMPORARY RUSSIAN SEXOLOGY**

*Olga Burmakova*

Department of Political Science and Sociology, European University at Saint-Petersburg, Russia

Russia has come a long way since there was “no sex in the USSR”. But fast, uncontrolled and often turbulent changes in the public discourses on sexuality have led to certain unbalance in the understanding of the topic even among the health professionals such as sexologists. In the last few years, sexuality came to the attention of the state’s nationalist project which brings yet another set of changes not only in the public discourse, but to the goals and abilities of the health professionals working with sexual health. The paper offered for the conference is a preliminary study for my doctoral research on contemporary Russian sexology. I present the analysis of 10 expert interviews with health professionals (sexologists, psychotherapists, gynecologists etc.) as well as the professors teaching sexology to the will-be professionals. To contextualize my analysis I overview the classic and contemporary Russian literature on sexology and sexual health, such as textbooks and journal articles. The results show that there are several trends in modern Russian sexology which reflect some of the wider political and social trends, such as the idea of the specifically Russian sexuality, inseparable from the soul. On the other hand, contemporary sexology presents the opposition for the nationalist project of moralistic sexuality centered on marriage and reproduction, by focusing on sexual health for all sexual identities and practices.

**57157**

**MALE GENDER ROLE IDENTITY AND HEALTH BEHAVIOURS: A RELATIONAL ANALYSIS OF UK COUPLES**

*Robert Meadows*

University of Surrey, UK

**INTRODUCTION:** The paper seeks to expand on previous qualitative work on masculine identity and health behaviour (Courtenay 2000; Robertson 2007). First, it uses large scale, representative data, to explore the association between male gender identity and health behaviours (whilst taking into account and exploring differences between men). Second, it explores how the link between male gender identity and health is relational; and how within heterosexual couples male gender identity may impact on female partner’s health (and vice versa).

**METHOD:** Data: A cross-sectional, secondary analysis study. Data come from Wave 2 (2010-2012) of the large-scale, nationally representative, UK Understanding Society survey. Understanding Society contains a battery of questions relating to gender role identity (Schober and Scott 2012) Analysis: (i) Bivariate/regression analysis with all men within the sample (n=19401) (ii) Actor-Partner Interdependence Models (APIM) on a subsample of men and women where data is available from both partners within a couple (n=13071 couples)

**RESULTS:** Age has a linear relationship with gender role identity – with older men more likely to express ‘traditional’ gender role identity than younger men. Those who have traditional gender views are more likely to drink alcohol frequently and are more likely to have smoked. Within couples, both own (-18.26) and partner (-4.48) gender identity are related to alcohol consumption. This is in part because of significant correlations in couples’ gender views (partial intra class correlation of 0.51).

**CONCLUSIONS:** Hegemonic masculinities are detrimental to the health of both men and women. The relational dynamic adds to ideas that we need to consider masculinities and health through the prism of ‘structural violence’ (Scott-Samuel et al 2009) and critique the idea that hegemonic masculinities are ‘curable diseases’.

## Session 2E: DISEASE CAREERS II

**Chair:** Rudolf Forster, Ludwig Boltzmann Institut Health Promotion Research, Vienna, Austria

**57214**

### **SPORT-ILLNESS NARRATIVES OF PEOPLE WITH BREAST CANCER, DIABETES AND HIV**

*Agnes Elling-Machartzki<sup>1</sup>*

*Mirjam Stuij<sup>1, 2</sup>*

*Tineke Abma<sup>2</sup>*

<sup>1</sup> Mulier Institute, The Netherlands

<sup>2</sup> Department of Medical Humanities, EMGO+ Instituut, VU University Medical Center, The Netherlands

**INTRODUCTION:** Nowadays sport and physical activity are often included in treatment of chronic illness as important technologies for medical recovery and to recapture embodied self-worth. Dominant sport-illness narratives best fit Frank's restitution narrative and provide a selective map that affects social perceptions and personal experiences. Physical activity and sports might not by everyone (only) be associated with positive meanings and recovery. In our ongoing mixed methods study we analyse the (re)construction and negotiations of sport-illness narratives among people with different chronic illness and social status positions (breast cancer, diabetes, hiv).

**METHOD:** We collected online questionnaires among adult people with breast cancer (n=104), diabetes (n=181; 42% type 1) and hiv (n=252) through patient organisations. Questionnaires included statements and short (sport)illness stories with scale options of recognition.

**RESULTS:** Among all patient groups the restitution (sport-)illness narrative is most dominant. Breast cancer patients most often (also) adopt a quest narrative. Sport and physical activity form an important marker of health for many patients of all groups (49-63%). The meaning of sport has often (positively) changed, although especially hiv and diabetes type 2 patients also give more resistant meanings to sport and well being.

**CONCLUSIONS:** The (changed) meaning of sport and physical activity in relation to managing illness for different patient groups show important similarities. However, also meaningful differences related to specific illness characteristics, social determinants and experienced well being were found. These results require more detailed qualitative inquiry that contributes to better and more tailored guidance with respect to sport and physical activity in the treatment trajectories of patient groups.

**57325**

### **EDUCATIONAL TRAJECTORIES AFTER CHILDHOOD CANCER: A CONTRIBUTION TO THE HEALTH SELECTION HYPOTHESIS**

*Agnes Dumas<sup>1</sup>*

*Philippe Amiel<sup>1</sup>*

*C. Perrey<sup>1</sup>*

*F. De Vathaire<sup>2</sup>*

<sup>1</sup> Gustave Roussy Institute, Social Sciences Research Unit, France

<sup>2</sup> Inserm Center for Research in Epidemiology and Population Health, France

**INTRODUCTION:** Poor health in childhood may result in lower socioeconomic status in adulthood, and, therefore, contribute to social inequalities in health. Children or adolescents who have a chronic disease may have reduced school performances related to lost time of schooling. Another possible mechanism is that they would project in short-term educational goals. Childhood cancer, one of the most frequent pediatric diseases, may induce fear of recurrence and uncertainty about life expectancy. It constitutes an interesting paradigm to explore mechanisms at stake in the health selection hypothesis.

**METHOD:** A qualitative life course perspective was used to assess the subjective role of childhood cancer in educational trajectories. Eighty French adults who had childhood cancer were randomly selected from a cohort on late effects and were interviewed about perceived impact of cancer on their life course.

**RESULTS:** Reduced projection in long-term educational goals because of a fear of a short life expectancy was rarely reported. School failure was described by interviewees who followed a disability trajectory afterwards. School dropout was reported by women who viewed early transition into the workforce as a

way to move over the traumatic experience of cancer. On the contrary, physical impairment, or sometimes, representations about the trajectory of the illness, led men to give up a vocational project. This change consisted in giving-up physical occupations for white collar ones, and often resulted in an upward intergenerational mobility.

**CONCLUSIONS:** Childhood cancer affected educational choices and trajectories during adolescence – and, thus, socioeconomic status in adulthood – through gendered mechanisms.

**56964**

**INFLAMMATORY RHEUMATISMS AND CHRONIC KIDNEY FAILURE – COMPARING THEIR CONSEQUENCES ON PATIENT’S CAREER TRAJECTORY**

*Carla Ribeiro*

Sociology Institute, University of Neuchâtel, Switzerland

**INTRODUCTION:** Although many studies have analysed the consequences of a chronic illness on individual’s life in general, in Switzerland, as in other countries, only scant research deals in a comparative perspective with different, specific diseases, and how they impact on individual career trajectories. Interpretative perspectives argue that a chronic disease onset brings out important life changes, because illness trajectory imposes itself to individual’s life. Therefore, the working individuals who are chronically ill may be excluded from the labour market due to chronic illness’ characteristics (uncertainty, unpredictability, symptoms management, disability and impairment), the requirements of the labour market, and the patients’ low health capital. The aim of this paper is to analyse, compare and describe the consequences of two specific chronic diseases, inflammatory rheumatisms and a chronic kidney failure, on the patients’ career trajectories.

**METHOD:** Data comes from 36 biographical interviews (longitudinal biographical approach) with 30-60-years-old patients (diagnosed with inflammatory rheumatisms and kidney insufficiency) with professional experience.

**RESULTS:** The results show that the magnitude of illness’ consequences on career trajectory, result from three main factors: 1) disease characteristics (namely the trajectory, severity and response to treatments); 2) individuals characteristics (psychological factors, socio-economic factors, work characteristics and professional experience); 3) structural factors (medical advancements and professional rehabilitation politics). These factors influence the work disability after illness onset and thus the career transitions. The career transitions vary from permanent work cessation or inability to work in the same job to reduction of working hours and professional reorientation.

**CONCLUSIONS:** The findings aim to contribute to a better knowledge regarding the interaction between process and structure, and thus to better define professional rehabilitation politics.

**Session 2F: WORK AND WELL-BEING I, pre-organized symposium: Work, health and disability: a life-course approach to labour market participation using register data from Nordic countries**

**Organizer and chair: Tea Lallukka, Finnish Institute of Occupational Health, Finland**

**50623**

**PSYCHOTROPIC MEDICATION USE AND RISK OF WORK-RELATED INJURIES**

*Anne Kouvonen*<sup>1, 2</sup>

*Jussi Vahtera*<sup>3, 4</sup>

*Tuula Oksanen*<sup>3</sup>

*Jaana Pentti*<sup>3</sup>

*Paula Salo*<sup>3</sup>

*Marianna Virtanen*<sup>3</sup>

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**INTRODUCTION:** The aim of this study was to examine psychotropic medication use as a risk factor for work-related injuries.

**METHOD:** 66,238 Finnish public sector employees (81% women) participated in this cohort study. Participants responded to the survey in 2000-2002, 2004 or 2008 and the mean follow-up was 7.8 years. Data on psychotropic drug purchases were derived from the national Drug Prescription Register. Prescription data were linked to records of work-related injuries. Cox proportional hazards models were applied. Psychotropic medication use treated as a time-dependent exposure that could change in value over the course of observation.

**RESULTS:** After adjustments, antidepressant use was associated with an increased risk of commuting injuries (HR=1.23; 95% CI: 1.11-1.36). The use of hypnotics was associated with an elevated risk of both occupational (HR=1.14; 95% CI: 1.02-1.28) and commuting injuries (HR=1.18; 95% CI: 1.02-1.37). The use of anxiolytics and sedatives was not associated with work-related injuries.

**CONCLUSIONS:** Psychotropic medication use may increase the risk of work-related injuries, commuting injuries in particular.

**51731**

**THE JOINT CONTRIBUTION OF PAIN AND INSOMNIA TO WORK DISABILITY AMONG NORWEGIAN AND FINNISH EMPLOYEES**

*Tea Lallukka*<sup>1, 2</sup>

*Simon Øverland*<sup>3, 4</sup>

*Peija Haaramo*<sup>1</sup>

*Peppiina Saastamoinen*<sup>1</sup>

*Bjorn Bjorvatn*<sup>5, 6</sup>

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**INTRODUCTION:** Pain and insomnia are both prevalent and persistent problems among employees, and they are associated with sickness absence and disability retirement. However, their joint contribution to

work disability has not been studied. The aim of this study was to examine the associations of pain and insomnia with work disability, with a particular focus on the synergistic effects. The associations were tested in two occupational cohorts to improve generalizability.

**METHODS:** Norwegian Hordaland Health Study (n=6,892, 59% women) and Finnish Helsinki Health Study (n=6,060, 78% women) survey data, linked with national and employer's register data on work disability were used. The outcomes were medically certified long sickness absence spells (2 weeks or more, four-year follow-up) and all-cause disability retirement (five-year follow-up). Pain and insomnia were self-reported at baseline. Poisson and Cox regression models were fitted, adjusting for sociodemographic and health-related covariates.

**RESULTS:** Reporting only pain or only insomnia was associated with the examined work disability outcomes in both cohorts. Moreover, the associations were strongest among those reporting both pain and insomnia supporting a synergistic interaction effect. The associations remained after full adjustments.

**CONCLUSIONS:** This study highlights the significance of both pain and insomnia as well as particularly their co-existence to work disability across occupational cohorts.

**55006**

### **MENTAL HEALTH, EMPLOYMENT AND WORK DISABILITY AMONG YOUNGER AND OLDER EMPLOYEES**

*Marianna Virtanen<sup>1</sup>*

*Kirsi Ahola<sup>1</sup>*

*Mika Kivimäki<sup>1, 2</sup>*

*Jussi Vahtera<sup>1, 3</sup>*

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<sup>3</sup> Department of Public Health, University of Turku, Finland

**INTRODUCTION:** To increase participation in the labour market is highly important also among people with mental health problems. Two studies are presented; first, characteristics of young adults with work disability due to mental disorders are presented. Second, the association of working conditions and health with extended employment in a cohort of older, non-disabled employees who reached old-age retirement is examined.

**METHODS:** The first sample was collected from pension institutes (n=1193, 56% women, aged 18-34 years), who were granted a fixed-term work disability pension due to mental disorder in 2008. The second population comprised 4677 Finnish municipal employees who reached their old-age pensionable date between 2005-2011 (mean age 59.8 years in 2005, 73% women) and had their survey responses before pensionable age linked to national registers.

**RESULTS:** Young adults disabled due to mental disorders had lower education than the general population of that age group. Almost half of them had a psychotic disorder (e.g., schizophrenia or bipolar disorder) and more than a third had depression. Less than 40% were employed when granted the disability pension. Of the older municipal employees, 18% extended employment by more than 6 months beyond the pensionable date. Good mental health in combination with the opportunity to control work time were the strongest predictors of extended employment.

**CONCLUSIONS:** Young adults with work disability due to mental disorders are characterised by low education, low employment rate and severe mental disorders. In older, non-disabled employees, good mental health and working conditions are both associated with extended working careers.

**56920**

### **PSYCHOSOCIAL WORK ENVIRONMENT AND RISK OF DEPRESSION: CURRENT KNOWLEDGE AND CHALLENGES**

*Ida E. H. Madsen<sup>1</sup>*

*Reiner Rugulies<sup>1, 2, 3</sup>*

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<sup>2</sup> Department of Public Health, University of Copenhagen, Denmark

<sup>3</sup> Department of Psychology, University of Copenhagen, Denmark

**INTRODUCTION:** Depressive disorders are a leading cause of disability worldwide. The causes of depression are believed to be found in a complex interplay between biological, psychological and social

factors. The associations between psychosocial work environment factors and depression have been under scrutiny for years, as the workplace may present a suitable setting for interventions. However, it is still unclear if there is a causal effect of the psychosocial working environment on depressive disorders. A major concern is that most studies in the area have measured the examined exposures by self-report, which might bias associations away from the null.

**METHOD:** We conducted a selective literature review of the recent literature on psychosocial work environment factors and the development of depression.

**RESULTS:** There is relatively consistent evidence of an association between self-reported psychosocial work environment factors and depression, although indications of publication bias exist. During recent years, a number of studies have been published using non-self-reported exposure measures. The methods of these studies include work-unit aggregation of exposure, instrumental variable analysis, and trajectory analysis. The results of these studies, however, are somewhat inconsistent, and associations are found in some but not all studies.

**CONCLUSIONS:** The published literature indicates that there is an association between self-reported psychosocial work environment factors and clinically significant depression. Some recent studies suggest that this association may be causal, although methodological issues remain, including publication bias and occupational selection.

**56942**

## **MENTAL HEALTH, PAIN AND SLEEP PROBLEMS AS PREDICTORS OF WORK DISABILITY**

*Børge Sivertsen*

Norwegian Institute of Public Health, Norway

**INTRODUCTION:** Rates of disability pension (DP) awards remain high in most developed countries. The aim of this presentation is to provide an overview of recent Norwegian studies exploring the impact of common mental disorders, sleep problems and pain conditions on work disability.

**METHODS:** Information from two large cohort studies on mental and physical health in individuals aged 20-89 were linked to a comprehensive national database of disability benefits. Anxiety and depression were defined as scores on the Hospital Anxiety and Depression Scale of  $\geq 8$ , and insomnia was defined according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). The outcomes were incident award of a DP and sick leave during 1-7-year follow-up.

**RESULTS:** In short, all out data provide evidence of both anxiety and depression being strong and underestimated predictors of subsequent dropout from the working life. Also, both short sleep duration and insomnia were linked to subsequent sick leave spells and award of disability pensions. The impact of sleep problems was especially strong in combination with comorbid pain conditions.

**CONCLUSIONS:** The long-term occupational impact of anxiety, depression, pain and sleep problems is substantial, and calls for increased awareness as a public health concerns.



## **PARALLEL SESSIONS III**

### **THURSDAY 28 August at 15.30 - 17.00**

#### **Session 3A: HEALTH CARE II, pre-organized session: Health care systems and health inequalities 2**

**Organizers and chairs: Simona Olivadoti and Mara Tognetti Bordogna, University of Milan-Bicocca, Faculty of Sociology,**

**56911**

#### **A CROSS-NATIONAL COMPARATIVE STUDY ON THE ROLE OF INDIVIDUAL LIFE COURSE FACTORS ON MAMMOGRAPHY SCREENING**

*Sarah Missinne*

University of Ghent, Department of Sociology, Belgium

The impact of national mammography screening programs for reducing socio-economic inequalities remains unclear. A cross-national comparative approach can yield insights into how mammography screening practices are embedded within the institutional context of a country's health care system. Also, within the theoretical framework of cultural health capital and the life course perspective it has been argued that a longitudinal view is needed to understand the social rooting of preventive health care inequalities. Previous studies have found that childhood preventive health practices are positively related to mammography screening in Belgium, even after childhood and adulthood socio-economic position (SEP) and health are controlled for. The question now is whether and how these lingering effects from childhood socialization depend upon the institutional context. For this purpose, we examine the role of childhood socio-economic factors and preventive health practices on mammography screening initiation in 13 European countries. The survey of health, ageing and retirement (SHARELIFE) provides retrospective data which allows to incorporate the historical evolution of national screening policies. Event history analyses have revealed that childhood preventive health care use is positively associated with mammography screening in all European countries. Except for 3 countries (Sweden, The Netherlands & Germany), this effect remains even after including childhood and adulthood SEP, as well as screening policies. In Sweden, it seems that the national screening programme, which is the most longstanding and far-reaching, can alter childhood disadvantages. In The Netherlands and Germany other factors are at play. Despite remaining socio-economic inequalities in many countries, the institutional context of mammography screening seems very important. Researchers should revert to early life to reveal the mechanisms underlying preventive health care inequalities.

**56996**

#### **EQUALITY AND INEQUALITY IN HEALTH CARE: THE CASE OF MENTAL HEALTH**

*Giuseppina Cersosimo*

University of Salerno, Italy

This paper is based on the observation that some certainties in care and rehabilitation of mentally ill people have not been and are not yet sufficiently guaranteed; furthermore discrimination and inequalities are generated by a certain kind of science and politics. Mental illness compounds the problem of the "ethics of access" concerning who guarantees the right to equity in care of the mentally ill patient and how. So we conducted a study (with qualitative and quantitative methods) at a Diagnosis and Care Psychiatric Service (DCPS) located in the South of Italy on the border between two provinces. We have observed and stated that some inequalities in care are redressed when dramatic situations must be coped with, so that the more the situation is dramatic, the more inequalities will be prevented. At the same time we have observed that in relation to some phenomena and etiologies, unlike others, inequalities in treatment do persist. Therefore we have worked out and developed a possible model to redress the imbalance, by drastically redesigning the agreements among public, private, para-private and social private services by means of innovative systems targeted to users and their families, rather than to facilities.

59083

## **INFORMAL PAYMENT IN THE HUNGARIAN HEALTH SECTOR. SOCIOLOGY OF NON-REFORM**

*Gábor Eröss*

Centre for Social Sciences, Hungarian Academy of Sciences, Hungary

The phenomenon of gratitude/informal payment has been present in the Hungarian health care system for at least 60 years. Our papers' core question is the following: what are the mechanisms behind the procrastination of decisive policy steps regarding informal payment, despite the declared willingness of policy makers to ban it? What sociological factors have been undermining evidence-based policy in this case? Our research invokes the public action approach (Commaille 2004), that emerged from the French sociological literature. Thus, consideration is given to the whole process of policy formulation. Accordingly, we use on the one hand qualitative methods: observations, in-depth interviews with actors from all levels (from ministers, to lobbyists to doctors), and document analysis (incl. political programmes, laws, work-in-progress documents, etc). On the other hand, we analyse those quantitative data (statistics, surveys and research papers based on these data) that informed the policy makers about informal payment. Decision-makers were confronted with data underlining a double inequality. First, gratitude payment contributes to unequal access to health care: those who are able to pay gain a better and faster access, thus: a better health care. On the other hand, as reports have shown, the inequalities are extreme between various subgroups of health professionals. The persistence of informal payment is fundamentally related to the perception and understanding of it by the policy makers – their knowledge of the phenomenon. However decision-makers, rather than basing their decisions of the above mentioned data, personally identified the physicians' corporation as a monolith group fiercely attached to the privilege of receiving informal payment, which lead to non-reform. Instead of knowledge-as-evidence we find non-knowledge (Beck 1996, Weingart 2003, Wehling 2006) and specified ignorance (Merton 1987). This leads us to political agnatology (Eröss 2009) ignorance-based policy (Eröss 2009b) and the rise of "authentic" personal knowledge of the decision makers.

## **Session 3B: MENTAL HEALTH III**

**Chair: Eero Lahelma, University of Helsinki, Finland**

55730

## **COMMON MENTAL DISORDERS AND SUBSEQUENT MORTALITY**

*Eero Lahelma<sup>1</sup>*

*Olli Pietiläinen<sup>1</sup>*

*J. Lahti<sup>1</sup>*

*T. Lallukka<sup>2</sup>*

*Ossi Rahkonen<sup>1</sup>*

<sup>1</sup> Hjelt Institute, Department of Public Health, Helsinki, University of Helsinki, Finland

<sup>2</sup> Finnish Institute of Occupational Health, Helsinki, Finland

Common mental disorders (CMD) are prevalent among adult populations. CMD contribute to mortality, but their associations with mortality are inadequately understood. We examined whether CMD, indicated by two instruments, contribute to mortality, while considering key covariates. Helsinki Health Study cohort data on 40-60-year old municipal employees were used. Baseline surveys were made in 2000-02 (n=8960, 80% women, response rate 67%). CMD were measured at baseline by General Health Questionnaire (GHQ-12) dichotomised to scores 0-2 and 3-12, and Short Form 36 Mental Component Summary (MCS) dichotomised by the lowest quartile. Covariates included sociodemographics, working conditions and health related factors. Data on deaths by the end of 2012 were obtained from Statistics Finland (men 73, women 138). Mortality data were linked to the survey data for those consenting to linkage (n=6565). Hazard ratios (HR) and 95% confidence intervals (CI) were calculated using Cox regression analysis. The prevalence of GHQ-12 scores 3-12 was 25% corresponding to the lowest quartile of MCS. GHQ-12 showed no associations with mortality. Similarly there were no associations between MCS and mortality among women. However, among men MCS was associated with mortality after adjusting for age and gender (HR 1.84, CI 1.13-3.01). This association remained even after adjusting for work and health related covariates. In this study the association of CMD with subsequent mortality was specific to gender and

CMD measure. Only mental health functioning (MCS) predicted mortality and only among men. Our findings are in partial accordance with previous ones, warranting further investigation.

**57287**

### **THE IMPACT OF UNINTENDED PREGNANCY ON DEPRESSIVE MOOD IN EUROPE**

*Rozemarijn Dereuddre*

Ghent University, Belgium

**INTRODUCTION:** The transition to parenthood entails severe changes in people's lives and, consequently, one of the focal points in related research concerns its consequences for parents' health after childbirth. Much less attention is paid to preceding pregnancy intentions. Although several studies indicate that unintended pregnancy is related to maternal risk behaviour during pregnancy and negative health effects on the child after pregnancy, research concerning its impact on both parents' antenatal (mental) health is scant. **OBJECTIVES:** This study aimed to examine the relation between pregnancy intention and antenatal depressive mood for both men and women. We distinguished between mistimed and unwanted (by one partner or both partners) pregnancy.

**METHODS:** We used data of the Generations and Gender Survey, collected between 2004 and 2008, and pooled the information of all pregnant heterosexual couples of eight European countries (N men = 578; N women = 658). Gender differentiated negative binomial regression analyses were performed.

**RESULTS:** Our results suggest that, irrespective of age, education, partner status, household size and country, men show significantly lower depression scores if their partner is pregnant. When including the internal interaction term measuring pregnancy intention, unintended pregnancy seems to be related with higher depression scores compared to intended pregnancy, for both men and women. Distinguishing between mistimed and unwanted (by one or both partners) pregnancy, we find significantly higher depression scores for men concerning mistimed and unwanted pregnancy by one partner compared to intended pregnancy. No significant differences were found for women.

**CONCLUSIONS:** These first results point towards some important gender differences in the impact of unintended pregnancy on depression scores and urge us to further analyse possible gendered mediating pathways linking pregnancy intentions and depressive mood. The need of taking men's experiences into account is clearly highlighted. Rozemarijn Dereuddre & Piet Bracke (Ghent University)

**57212**

### **PSYCHIATRIC DISORDERS AMONG MIDDLE-AGED COUPLES AND THE RISK OF SUBSEQUENT DIVORCE**

*Niina Metsä-Simola<sup>1</sup>*

*Pekka Martikainen<sup>1</sup>*

*Christiaan Monden<sup>2</sup>*

<sup>1</sup> Population Research Unit, Department of Social Research, University of Helsinki, Finland

<sup>2</sup> Nuffield College, University of Oxford, UK

**INTRODUCTION:** Studies that assess the role of mental health for the risk of divorce are scarce and mostly rely on individual-level data, although divorce is a couple-level phenomenon. Using couple-level data, we examine if male and female psychiatric morbidity have similar effects on divorce risk, and whether spousal comorbidity has an effect on top of the individual risks of both partners.

**METHOD:** We followed 96,222 Finnish married and initially healthy couples aged 40 to 64 from 1998 to 2003 for incidence of psychiatric disorders and subsequent divorce using register-based data on both partners. The data included dates of divorce, prescription medication purchases, entries to and exits from hospitals, and annual socio-demographic characteristics. The effect of incident psychiatric morbidity on divorce risk was analyzed using Cox regression for couples.

**RESULTS:** We observed 22,991 couples with new incidence of psychiatric disorders, the number of divorces being 7,932. Compared to couples with no psychiatric morbidity, male disorder incidence increased subsequent age-adjusted risk of divorce more than two-fold (HR=2.33, 95% CI=2.13-2.54) and female morbidity somewhat less (HR=1.84, 95% CI=1.71-1.98), the risk of divorce being three-fold (HR=2.98, 95% CI=2.53-3.51) after spousal comorbidity. Adjustment for socio-economic factors had little effect on these associations.

**CONCLUSIONS:** Psychiatric morbidity is a major risk factor of divorce independent of socio-economic disadvantage, and this increased risk produces marital status differences in mental health. The results

suggest relationship quality and satisfaction are major factors affecting divorce risk. Further research is needed to explore why male morbidity has larger effect than female morbidity.

**59233**

### **DRINKING HABITS AND MENTAL HEALTH FUNCTIONING - A PROSPECTIVE STUDY AMONG AGEING EMPLOYEES**

*Aino Salonsalmi<sup>1</sup>*

*Mikko Laaksonen<sup>1, 2</sup>*

*Eero Lahelma<sup>1</sup>*

*Ossi Rahkonen<sup>1</sup>*

<sup>1</sup> Department of Public Health, Hjelt Institute, University of Helsinki, Finland

<sup>2</sup> Finnish Centre for Pensions, Finland

**INTRODUCTION:** Poor mental health is a major threat to employee health causing for example reduced work ability and early retirement. Alcohol drinking is prevalent among ageing employees and might lay behind poor mental health functioning. The study aimed to examine whether alcohol drinking is associated with poor mental health functioning five to seven years later among ageing municipal employees.

**METHOD:** The baseline data were collected in 2000-02 and the follow-up data in 2007 by postal surveys among employees of the city of Helsinki aged 40- to 60 years at baseline. Both surveys included questions about weekly average drinking, binge drinking and problem drinking measured by the CAGE-scale as well as the Short-Form 36 questionnaire on mental health functioning. Logistic regression was used in performing the analyses and the results are presented with odds ratios (OR) and 95% confidence intervals (CI). The study includes 5577 women and 1284 men.

**RESULTS:** Among both women and men heavy average drinking, binge drinking and problem drinking at baseline were all associated with belonging to the lowest quartile in mental health functioning at follow-up. After adjusting for baseline mental health functioning, socio-demographic factors, working conditions and other health behaviours the associations between problem drinking and subsequent poor mental health functioning remained (OR 1.53, CI 1.29-1.82 for women and OR 1.50, CI 1.09-2.05 for men).

**CONCLUSIONS:** Especially problem drinking predicts poor mental health functioning among ageing employees. Preventing adverse alcohol drinking is likely to prevent poor mental health functioning.

## **Session 3C: HEALTH POLICY AND SERVICES II**

**Chair: Sakari Karvonen, National Institute for Health and Welfare (THL), Finland**

**57379**

### **‘LOVE THEM OR HATE THEM’: THE ‘ARROGANT BUBBLE’ AND DIS/TRUST IN THE POSTSOCIALIST BIRTH CARE SYSTEM**

*Ema Hresanova*

University of West Bohemia, Czech Republic

**INTRODUCTION:** In this paper I pick up the thread of Mike Dent’s previous notes on post-socialist healthcare system in Europe. According to Dent those European countries that were under the Soviet influence tend to manifest a high polarization of trust in the healthcare systems, and most people tend to ‘either love or hate’ their doctors while just a few hold a balanced critical view. This paper points to similar tendencies in the postsocialist Czech Republic while it particularly focuses on a specific domain of birthcare surrounded by similar dichotomous discourses. I especially examine the perspective of those who communicate an inherent distrust in the birthcare system and aim to show what lies behind.

**METHODS:** This examination is built on thematic analysis of 25 narrative interviews with women who preferred ‘natural childbirth’ with minimal medical interventions, which were conducted from June 2012 to February 2014.

**RESULTS AND CONCLUSIONS:** Distrust in the system of healthcare and hospital environment constituted one of the most significant themes in the narratives. Many participants mentioned their own previous negative experience, birth care providers’ paternalism and disrespectful attitudes as the main source of their distrust. My participants criticized an ‘arrogant bubble’ around childbirth created by obstetricians who denounced homebirths but never acknowledged potentially harmful consequences of

procedures which they routinely perform in hospitals. Interviewees' assessments of hospital staff, however, strikingly differed from the way in which they perceived other physicians providing them maternity and postpartum care in their outpatient's departments. This points to the importance of 'relational continuity' in birthcare provider-receiver relations.

**59405**

**THE JANUS-FACED ANATOMY TECHNICIAN: LIAISING WITH FAMILIES OF WHOLE BODY DONORS TO MEDICAL SCHOOLS**

*Julie Seymour*

*Trish Green*

Hull York Medical School, UK

**INTRODUCTION:** Anatomical bequeathal is the donation of bodies after death for the purposes of medical teaching and research. There has been a continuing international shortage of bodies donated for this purpose. Research on donation suggests that (contrary to lay beliefs) those donating bodies are not isolated but are often enmeshed in family networks (Bolt et al., 2010; Cornwall et al., 2012). There is also evidence to show that body donation runs in families. Hence, the experiences of the donation process by surviving family members may lead to further body donations in the future. However, there has been little research on the liaison activities that Anatomy Unit personnel have with family members following a body donation. In addition, thanatology studies do not address the involvement of family members in death rituals, mourning and body disposal when they occur some three to five years after death and donation to an Anatomy Unit.

**RESULTS AND CONCLUSIONS:** This paper outlines the case for examination of this process from the viewpoint of both the Anatomy Unit staff and the families of the donor. It details the requirement for this research to incorporate the stages of body refusals, interim contact, body disposals and thanksgiving services. It draws on developing work on natural burials to highlight the tension between collective memorialisation and individual 'family displays' of memory-making, thus linking death studies with emerging concepts in family studies. The paper also discusses the development of good practice guidelines for Anatomy Unit staff and bereavement counsellors.

**57246**

**FAILURE TO PROMOTE THE CAUSE OF ORGAN DONATION: THE CASE OF PATIENTS' ASSOCIATIONS IN SWITZERLAND**

*Raphaël Hammer*

*François Kaech*

University of Health Sciences, Institute of Health Research, Switzerland

**INTRODUCTION:** Over the last years, organ donation in Switzerland has gained political and social visibility, thanks to legal changes and intensification of public information campaigns. However, Switzerland still faces an acute organ shortage and current public health policies are subject to criticism. Given the active part patients' organizations play in health-related areas, this communication deals with transplant patients' mobilization in Switzerland and focuses on why these associations have failed to promote organ donation as a social problem.

**METHODS:** This communication is based on thirty-two interviews carried out with members of the fifteen transplant associations existing in the French-speaking part of Switzerland.

**RESULTS:** Interviewees strongly challenge the government's lack of commitment to organ donation, focusing on the neutrality of public campaigns and the opting-in system. However, most of the associations show a very limited involvement in the public sphere. Their concrete activities reveal that they largely remain outside the health policy-making processes. Obstacles such as low financial resources and small number of members may explain such a limited involvement. Another important finding is the absence of cooperation between these associations, resulting in fragmentation of mobilization. One significant factor explaining unsuccessful attempts to develop common strategies is personification of the cause, revealing the ambivalence of some members' associative commitment.



**CONCLUSIONS:** Both structural factors and individual motivations shape forms of these associations involvement. The distinctive features of organ donation as a public good and of transplant patients' profile will be discussed, in comparison with other successful mobilization of patients, such as AIDS.

**59413**

**VALUE-FOR-MONEY REGULATION OF EXPENSIVE NEW MEDICINES: LEGITIMATING DECISIONS THROUGH THE TRANSFORMATION OF UNCERTAINTY?**

*Patrick Brown*<sup>1</sup>

*Ferhana Hashem*<sup>2</sup>

*Michael Calnan*<sup>2</sup>

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**INTRODUCTION:** Healthcare systems across Europe face increasing financial pressures, not least due to the costs of expensive new medicines. Amidst these challenges, new forms of regulatory systems are emerging including those assessing value-for-money (VFM). Institutions such as NICE in England have been designed in an attempt to resolve uncertainty regarding VFM prescribing, thus facilitating more appropriate, cost-effective and thus legitimate use of limited public/insurance monies. Yet, in England at least, the increased visibility of value-for-money decisions has led to heightening politicisation of access to medicines and legitimisation problems for NICE.

**METHODS:** Within this wider context, we explored the decision-making processes of NICE as they evaluated the cost-effectiveness of three medicines which we purposively selected. Triangulating observations of NICE technological assessment committee meetings, documentary analysis and interviews with a range of decision-makers and other stakeholders (n=41), we were particularly interested in exploring how decisions were reached despite uncertainty.

**RESULTS:** It was commonly considered that if all uncertainties were fully acknowledged then decisions would not be possible. Various forms of uncertainty, for example due to limited or insufficiently appropriate data, were therefore 'absorbed' and then transformed within the appraisal process. Some of these uncertainties were then confronted, while others remained submerged or were more purposively bracketed-out. Informed by Habermas, Moran and Simon, our analysis considers various tensions which exist between processes of pursuing legitimacy via quality decisions and the intractable problems of uncertainty lingering therein.

**CONCLUSIONS:** Whether resurfacing or remaining buried, uncertainties may come to form obstacles to the rationality, effectiveness and legitimacy of value-for-money regulation.

**Session 3D: GENDER AND HEALTH II**

**Chair:** Anu Katainen, University of Helsinki, Finland

**56881**

**THE SOCIAL CHALLENGES OF MEDICALLY ASSISTED PROCREATION IN ITALY. GENDER RELATIONSHIPS BETWEEN CHANGE AND INEQUALITIES**

*Lia Lombardi*

University of Milan; ISMU Foundation, Italy

**INTRODUCTION:** Italian context shows a great amount of contradictions between the advances of biomedicine and biotechnology and legislative and political conservatism. The assumptions of this research are: •The impact of reproductive technologies on gender relationships and on the new types of parenthood (homosexuals, single parents, etc.); •The link between Italian policies and laws and the changes in the social, family and parenting structures already found in our society; •The gender inequality, still rooted in the Italian context, that has to face the challenges of MAP, on the one hand, and the resistance of procreative conventional models, on the other.

**METHODS AND TOOLS:** This study uses an integrated research methodology which makes reference to the sociological and anthropological literature, to the international (as Eurostat, WHO, OECD) and national



(as ISTAT, ISS, RNPMA) databases, and to a qualitative research carried out in a local context (Fertility Center Hospital in Lombardy).

**RESULTS AND CONCLUSIONS:** The issues developed in this paper reveal, for the Italian society, some asymmetric, sometimes conflicting, pulses especially when gender equality is concerned. We can note, therefore, three main results: 1. The medicalization of everyday life and of human reproduction, while staying a tool of care and wellbeing, also represents an instrument of social control. MAP (Medically Assisted Procreation), through its offer and representation, reproduces gender stereotypes that gather attention to the female body, emphasizing the reproductive and maternal aspects of women's identity; 2. The high-tech medical advances in the reproductive field are not adequately reflected in the policies and laws which are prevalently conservative, especially towards women, homosexuals and single individuals; 3. The Italian society still shows significant gender gaps in employment and family care which has a negative impact on the parental project. These disparities are further accentuated because of the current economic crisis.

**56951**

### **THE GYNAECOLOGIST'S GAZE: THE INCONSISTENT MEDICALIZATION OF CONTRACEPTION IN CONTEMPORARY RUSSIA**

*Anna Temkina*

European University at St. Petersburg, Russia

**INTRODUCTION:** This article studies the medicalisation of contraception by gynaecologists in present-day Russia. I explore the disciplining discourse and tactics of gynaecologists as experts who aim to orient women towards properly planned and prepared pregnancy. I argue that in accordance with the demographic priorities of the state, doctors are more oriented towards pregnancy treatment than consultation on contraception, and they are inconsistent in their regulation of contraceptive use.

**METHODS:** The presentation builds on an analysis of in-depth thematic interviews with obstetrician/gynaecologists, textbook and observation. Gynaecologists are important agents of reproductive control, pregnancy planning and promotion of contraception in Russia.

**RESULTS:** The main purpose of advocacy is found in the necessity for women to plan pregnancy and avoid having an abortion. Doctors while educating women on contraception construct the norm of their proper behaviour - stable relationship and orientation towards childbirth under medical supervision. Women are presented unambiguously as mothers who should regulate their life and take responsibility for their fertility with the help of contraception.

**CONCLUSIONS:** Gynaecologists' advocate all-encompassing and comprehensive oversight over contraception; However in health care, the biopolitical priorities of the state are pregnancy treatment and not contraception advocacy. While the orientation of professionals and service users alike is to use contraception and plan pregnancy, institutional barriers and state priorities facilitate service for pregnant women and not for pregnancy prevention.

**56572**

### **COMMUNICATION OF CAREGIVERS WITH TERMINALLY-ILL CANCER PATIENTS ABOUT ILLNESS AND DEATH: GENDER DIFFERENCES**

*Sara Carmel*

*Nilly Y. Sela*

*Yaacov G. Bachner*

The Center for Multidisciplinary Research in Aging and M.A. Program in Gerontology, Ben-Gurion University, Israel

**INTRODUCTION:** Literature documents the importance open communication, and difficulties of primary caregivers in communicating about illness and death with their loved ones. This study focuses on the contribution of caregiver characteristics and situational variables to the explanation of open communication by both genders.

**METHODS:** Seventy-seven spouses and primary caregivers of terminal cancer patients were interviewed for this study - 29 males and 48 females. The questionnaire was comprised of personal characteristics (age, gender, education level, optimism, and self-efficacy), measures of caregiver communication, and duration and intensity of care.

**RESULTS:** Female spouses communicated significantly more than males with their loved ones about illness and death. Results of multivariate analyses showed that among male caregivers, being of Western vs. Eastern origin and shorter vs. longer duration of care were best predictors of caregiver level of communication, in a model that explained 44.1 percent of the variance. Among females, self-efficacy and ethnic origin were significant predictors of level of communication, and the model explained 30.5% of the variance.

**CONCLUSIONS:** Our findings highlight the role of gender and culture in primary caregiver communication about illness and death with terminally-ill cancer patients. These factors should be considered when developing training and intervention programmes focused on caregiver communication with dying patients.

**55617**

### **INTERSECTIONALITY AND UNDERREPRESENTATION IN A HEALTHCARE WORKFORCE: THE CASE OF ARABS IN ISRAEL**

*Yael Keshet*

*Ariela Popper-Giveon*

*David Yellin*

*Ido Liberman*

Western Galilee Academic College, Israel

**INTRODUCTION:** According to intersectionality theory, gender and ethnicity cannot be understood as analytically separate, but rather as mutually constructed. Ethnic diversity within the health care workforce is considered to play an important role in reducing health disparities among different ethnic groups. Moreover, gender correspondence between patient and physician may influence the provision of patient-centered care. Research objectives were to examine gender patterns of education, employment and representation in health and welfare services among the Arab minority in Israel (which comprises 20.5% of the population).

**METHODS:** We analyzed data from a social survey conducted by CBS, which included a representative sample of 7064 participants, and from 10 semi-structured in-depth interviews with Arab physicians working in the predominantly Jewish Israeli health system.

**PRINCIPAL FINDINGS:** Health and welfare professions constitute a sought-after and popular education and employment pathway among the Arab minority in Israel, but while the employment rates of Arab men academics in these professions are relatively high, those of Arab women academics are very low.

**CONCLUSIONS:** Arab women in Israel suffer dual marginality as women in patriarchal Arab society and as a minority in Israeli society. These impediments both restrict their opportunities to find employment in healthcare and welfare professions, and limit the possibility of forming female patient – female physician dyads, thereby reducing the extent of patient-centered care, which may significantly impact the process of care and its outcomes. We stress the importance of examining underrepresentation in healthcare workforce through using the theoretical approach of intersectionality.

## **Session 3E: DISEASE CAREERS III**

**Chair:** Piet Bracke, University of Ghent, Belgium

**57022**

### **SCREENING FOR COLORECTAL CANCER: LIFESTYLE BRIDGING CHANCES AND CHOICES**

*Paula Feder-Bubis*

Ben-Gurion University of the Negev, Israel

**INTRODUCTION:** The gap between professional and lay approaches to colorectal cancer (CRC) screening was studied in low and middle socio-economic status (SES) neighborhoods. Laypersons' perceptions of the screening context were analyzed to highlight SES differences as reflected in participants' lifestyle.

**METHODS:** This qualitative focus group study included 24 women and men, aged 50-68, insured members of a large HMO in Israel. It took place in their residential neighborhoods' primary-care community clinics.

Group discussions were taped, transcribed, and analyzed using grounded theory principles, and qualitative data analysis software.

**RESULTS:** The homogeneous study group of insured members who did not screen in the previous year was heterogeneous regarding screening history, health-service provider's perceptions and tendency to participate in screening (participants' choices). Laypersons' views revealed a significant overlap with conceptualizations in the preventive health literature, but the contextualization of CRC screening, elicited in focus groups discussions, showed that individuals engage in a specific health-behavior in line with their location in the social fabric (their chances) and lifestyle. Even though CRC screening is free in Israel, its adoption is not equally accessible to all.

**DISCUSSIONS:** These findings contribute to a re-examination of the dynamics of health-related lifestyle formation and maintenance. Based on our CRC screening findings, it seems that lifestyle encompasses not only the well-known agency driven choices and the structure-related chances; it is also an anchor of personal routine social action pattern that carries an agency-determined "structure" and priorities decisions within the SES structure.

**57445**

### **MULTIPLE SOCIOECONOMIC DETERMINANTS OF NONCOMMUNICABLE DISEASE RISK FACTORS: EXAMPLE OF THE FORMER SOVIET UNION COUNTRIES**

*Tuvshinjargal Chimed*

School of Health Sciences, University of Tampere, Finland

**INTRODUCTION:** Socioeconomic determinants play a considerable role in the distribution of noncommunicable disease (NCD) risk factors, and this can be especially critical in countries of the former Soviet Union (FSU). The aim of the study was to examine multiple socioeconomic determinants of the most common NCD risk factors by using reliable cross-country comparable data.

**METHODS:** Data from 15501 adults from six countries (Estonia, Georgia, Kazakhstan, Latvia, Russia and Ukraine) of the FSU participated in the World Health Survey (2002-2004) were analyzed. NCD risk factors were smoking, heavy alcohol use, overweight/obesity, low fruit/vegetable intake, and physical inactivity. Socioeconomic position was measured by education, current job and wealth quintile. Multivariable logistic regression analyses were performed, employing a general modelling approach.

**RESULTS:** Education was not associated with NCD risk factors for both sexes, except with smoking for men. Higher educated men were less likely to smoke. Current job had negative associations with low fruit/vegetable intake and physical inactivity. Additionally, it was positively associated with smoking for women and with overweight/obesity for urban men. By wealth quintile, richer respondents were more overweight/obese and had more fruit/vegetable intake. The richest women from rural areas led sedentary lifestyle, while being richer had a protective effect for men's smoking. Moreover, wealth was negatively associated with heavy alcohol use in some women.

**CONCLUSIONS:** It is essential to use all three dimensions of socioeconomic position in health inequality studies in order to detect the true picture for any particular population. In the FSU countries, current job and wealth were more important for many NCD risk factors than education. Thanks to: Patrik Finne, Cherian Varghese and Heini Huhtala Tuvshinjargal Chimed MD, MPH, PhD candidate School of Health Sciences University of Tampere

**56826**

### **STRUCTURAL AND BEHAVIOURAL EXPLANATIONS OF TUBERCULOSIS IN LATVIA**

*Andrejs Ivanovs*

*Ieva Salmane-Kulikovska*

*Ludmila Viksna*

Riga Stradins University, Latvia

**INTRODUCTION:** Tuberculosis (TB) continues to cause significant morbidity and mortality, especially in the low and middle-income countries. It has been established that socioeconomic status is the strongest predictor of health and disease causation and longevity. It has also been pointed to the cultural and behaviour explanations of disease causation (Annandale 1998, 93). The review of literature regarding determinants of TB epidemics (Lönnroth, et al. 2009) provides for classifying all the determinants of this disease into two categories – proximate risk factors that impair the host's defence against TB and other

diseases, and upstream determinants that lay behind the proximate factors. The aim of the current study is to reveal the impact of both structural and behavioural factors contributing to the causation of TB.

**METHOD:** The research study explored impact of a number of factors. The obtained results were compared to the nationally representative FinBalt study of 2012, as well as to the results of EU-Statistics on Income and Living Conditions study. The relationship between variables was tested by odds ratio (OR) emerging from the logistic regression analysis.

**RESULTS:** The most important risk factors contributing to the causation of TB are HIV infection (OR=43), imprisonment (OR=13), use of alcohol (OR=12), low income (OR=8), insufficient body mass index (OR=4). Other risk factors have OR<4. The study demonstrates that causation of tuberculosis is strongly influenced both by socioeconomic behavioural factors.

**CONCLUSIONS:** Structural, behaviour and health factors impact on causation of TB. TB control strategies should be addressed to proximate risk factors as well as on upstream determinants.

**57003**

### **PARENTS RESISTING TO MANDATORY VACCINATION - (RE)DEFINING THE BOUNDARIES OF LAY AND EXPERT KNOWLEDGE**

*Jaroslava Hasmanova Marhankova*

Charles University in Prague, Czech Republic

Czech Republic belongs among countries with rigid mandatory vaccination system. This paper focuses on parents who challenge this system with their decision to refuse their child's immunization. Twenty-two parents whose children were not vaccinated were interviewed and several participant observations were conducted at public lectures concerning immunization and on meetings of parent critical to vaccination. The paper analyzes the anti-vaccination movement as an arena where we can observe the negotiation over the role of the citizen in relation to one's own health. The anti-vaccination movement raises issues not only in relation to the way mistrust is formed towards the expert systems of biomedicine, but also in relation to the discussion about who decides what treatment is provided to those who cannot decide for themselves. The analysis focuses on the way in which parents themselves (re)interpret expert information concerning vaccination, create their own "scientific credibility", and define the meaning of responsibility for their own health and that of their children. It points out that health in their cases became a new form of morality that enables them to define themselves as responsible parents and simultaneously exclude some parents for this category. The paper discusses the implications of this process for their relationships with medical authorities and the (re)definition of lay and expert knowledge. It shows that the process of decision making concerning the vaccination produces also new form of subjectivities of parents who are posing specific ethical imperatives toward themselves and to others.

### **Session 3F: WORK AND WELL-BEING II: Work ability**

**Chair: Ossi Rahkonen, University of Helsinki, Finland**

**57125**

### **THREE DECADES OF WORK ABILITY IN FINLAND -POPULATION ATTRIBUTABLE FRACTION**

*Risto Kaikkonen<sup>1</sup>*

*Tommi Härkänen<sup>1</sup>*

*Ossi Rahkonen<sup>2</sup>*

*Raija Gould<sup>3</sup>*

*S. Koskinen<sup>1</sup>*

<sup>1</sup> National Institute for Health and Welfare (THL), Finland

<sup>2</sup> Hjelt Institute, Department of Public Health, University of Helsinki, Finland

<sup>3</sup> Finnish Centre for Pensions, Finland

**INTRODUCTION:** Limitations in functional capacity and more detailed in work ability have decreased substantially in Finland and also in other developed countries. There is a marked socioeconomic gradient in work ability but the possible changes of the causes of this gradient are poorly known.

**METHOD:** Aim was to analyze population attributable fractions (PAF) and count avoidable numbers of absolute cases. Furthermore the aim was to explain educational differences in work ability during the past three decades. Socioeconomic position (education), general health, health behaviour and functional capacity as well as work-related factors were expected to be the main determinants of changes in work ability and changes in them were observed. Our hypothesis was that educational differences can partly be explained by different main determinants during the 30-year period.

**RESULTS:** The study was based on three nationally representative surveys from three decades 1980–2010: 1) Mini-Finland, a comprehensive cross-sectional health interview, through health examination and complementary questionnaire, collected 1978–1980 from Finns aged 30–64 years (8 000, 96 % participation). 2) Health 2000 Survey, collected 2000–01 from Finns aged 30–64 years (5835, 89% participation). 3) Health 2011 Survey, based on Health 2000 (7964 Finns 73% participation). Analyses were done using Stata to produce PAF and predicted margins (PM).

**CONCLUSIONS:** There is evidence that socioeconomic differences (by education) varies in time and moreover the contribution of these factors varies in time. PAF justifies the potential that could be achieved when reducing these differences in work ability. Results suggest that improvements in working conditions, especially in physical working conditions, and reducing smoking particularly in employees with low level of education may markedly reduce educational differences even during the 21st century.

**57188**

### **OCCUPATIONAL COMPETENCE AND WORK ABILITY FROM YOUNG ADULthood TO EARLY MIDLIFE: A 15-YEAR LONGITUDINAL STUDY**

*Jorma Seitsamo<sup>1</sup>*

*Nina Nevanperä<sup>1</sup>*

*Jouko Remes<sup>1</sup>*

*Leila Hopsu<sup>1</sup>*

*Leena Ala-Mursula<sup>2</sup>*

*Marjo-Riitta Järvelin<sup>2, 3</sup>*

*Jaana Laitinen<sup>1</sup>*

<sup>1</sup>Finnish Institute of Occupational Health, Finland

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<sup>3</sup>Department of Epidemiology and Biostatistics, Imperial College London, UK

The study was funded by the Finnish Work Environment Fund (111252).

**INTRODUCTION:** Maintaining good work ability is an important factor among the efforts to lengthen work careers. Besides adjustments to physical and psychosocial work environment, and support to health and active lifestyle, also updating occupational skills can be an important modifier of work ability (WA). The purpose of this study was to examine longitudinally the effects of occupational skills to the level of WA from early adulthood (the participants were 31 years old) to early midlife (to the age of 46y).

**METHODS:** The study population comprised of employed 46-year-old men and women born in 1966 (n ~4000) from the Northern Finland Birth Cohort 1966 study. The summary measures of WA, occupational skills, demands of work, and health were assessed by questionnaires in 1997 and 2013. Baseline covariates covered gender, education, health behavior, and work history. General linear models with repeated measures were used to investigate the effects of work demands, health and occupational skills on WA. **RESULT:** Occupational competence had a strong positive impact on the level of WA. This relation remained even when all other factors were included into the models. The significant interaction between time and skills suggested that the importance of skills grew stronger over ageing.

**CONCLUSIONS:** These results suggest that occupational competence is one way to maintain good WA in midlife. Further studies are needed to investigate if age-related decrease in WA could be compensated by improving occupational competence.



53671

# **STRESS IN HOUSEHOLD AND FAMILY WORK – A NEGLECTED ISSUE OF HEALTH INEQUALITY IN WOMEN?**

*Stefanie Sperlich*

Medical Sociology, Hannover Medical School, Germany

**INTRODUCTION:** This study explores the mediating role of domestic stress on the effect of social status on women's health.

**METHODS:** Social status was assessed by a combined measure including school education and vocational training. Stress in household and family work was measured using the adopted effort-reward-imbalance (ERI) questionnaire for unpaid domestic work. Health was assessed by the Zerssen list of somatic complaints. We used a population-based sample of German mothers ( $n = 3129$ ) to determine the total, direct and indirect effects of education on somatic complaints by means of OLS regression-based mediation models. Inference about indirect effects controlled for possible confounders was determined by 95% bias corrected bootstrap confidence intervals.

**RESULTS:** We found significant total and direct effects of education (X) on somatic complaints (Y) as well as significant indirect effects of X on Y through the effort-reward ratio (M). When considering 'effort' and 'reward' separately, we found only low reward predicting poor health in low educated women. The strongest indirect effect of education on somatic complaints was through 'lack of social recognition of domestic work'. After controlling for all dimensions of reward, the effect of X on Y clearly decreased but remained significant.

**CONCLUSIONS:** The effect of women's education on somatic complaints is partly mediated through stress related to low reward of unpaid work. The findings suggest that research on social inequality in health would gain by taking greater account of stressful experience beyond paid work.

56789

# **WORKING LONGER: PAID EMPLOYMENT AFTER AGE 65 YEARS**

*Morten Wahrendorf*

*Bola Akinwale*

*Rebecca Landy*

*Katey Matthews*

*David Blane*

Centre for Health and Society, Institute for Medical Sociology, University of Düsseldorf, Germany

**INTRODUCTION:** There is much research about those who exit the labour market prematurely, however, comparatively little is known about those working longer. In this paper, we study characteristics of men and women in paid employment between age 65 and 69 years.

**METHODS:** Analyses are based on the Survey of Health Ageing and Retirement in Europe (SHARE) with comparable information across 17 European countries. Beside socio-demographic and health-related characteristics, the focus of our analyses lies on employment and work-related factors, including psychosocial stress at work (as defined by the demand-control and the effort-reward imbalance models) and characteristics of individuals' employment histories (e.g. occupational position). In addition – given the cross national nature of our data – we explore the relationship between specific indicators of social and labour market policies and working longer.

**RESULTS AND CONCLUSIONS:** Results show that those working longer were more likely to be male and to report good health and well-being. Further, we find consistent associations between continued employment and "good" working conditions (in terms of low work stress, advantaged occupational position and favourable employment histories). Further, continued employment into old age was more prevalent in countries with "integrative" labour market policies, in particular, policies that promote further education among older workers or invest in supported employment and rehabilitation services.



## **PARALLEL SESSIONS IV**

### **FRIDAY 29 August at 08.30 - 10.00**

#### **Session 4A: Pre-organized session: Recession and health in Europe I: Austerity, liberatization and health.**

**Chair and organizer: Tim Huijts, University of Oxford, UK**

**59386**

#### **WHAT PRICE AUSTERITY: A NATION'S HEALTH**

*Fiona Kiernan*

Mater Hospital, Dublin, Ireland, MSc London School of Economics, UK

**INTRODUCTION:** The impact of the 'Great Recession' was particularly strong in Ireland, where a decrease in public expenditure on health was exacerbated by lowered disposable income. Despite ongoing austerity measures, there has been no assessment of the impact of fiscal constraint on the health of citizens. This research aimed to determine if access to healthcare was affected by the implementation of austerity measures.

**METHODS:** Data from national household surveys (Survey of Income and Living Conditions, and the Household Budget Survey) were examined. Markers of access to care included unmet medical and dental needs, health insurance or a GMS medical card, and out-of-pocket payments on healthcare. SILC data was analysed using a Chi square test, followed by a logistic regression. HBS results were analysed using an independent t-test and multivariate linear regression.

**RESULTS:** A statistically significant increase in unmet need was found due to austerity. There was no evidence of an effect on the numbers of those with GMS medical cards. A statistically significant increase in out-of-pocket payments as a share of disposable income was seen for all total out-of-pocket payments, except those due to prescription charges. The increase in fees due to austerity was particularly felt in income quintiles 2, 3 and 4.

**DISCUSSIONS:** This demonstrates that austerity affected access to care in Ireland, as shown by unmet needs. Assessment of out-of-pocket payments, revealed that citizens are paying a higher proportion of income on user fees than pre-austerity. Notwithstanding some limitations, this dissertation raises concerns regarding the ongoing use of austerity measures without adequate assessment of their effect on healthcare.

**56704**

#### **TRADE LIBERLIZATION AND HEALTH: THE MFA PHASE-OUT AND CHANGES IN ADULT AND INFANT MORTALITY RATES**

*Fiona McNamara*

Department of Social Policy and Social Work, University of York, UK

The health impacts of trade liberalization have begun to receive more attention in public health scholarship. However, this research is largely focused on factors related to healthcare privatization, changing dietary patterns, tobacco use, alcohol consumption, and access to medicines. Relatively little work has considered the impacts of trade liberalization on the social determinants of health. The purpose of this study was to investigate the health impacts of a major liberalization episode in the textile and clothing (T&C) sector: the phase-out of the Multi-Fibre Arrangement (MFA) in 2005. This phase-out triggered substantial shifts in employment, a central social determinant of health, across a range of high-, middle-, and low-income countries. Data from 32 T&C reliant countries were analysed in reference to the pre- and post-MFA periods of 2000-2004 and 2005-2009. Fuzzy-set qualitative comparative analysis (fsQCA) was used to examine the association between a) T&C employment changes, b) countries' level of labour market and welfare state protections and c) changes in adult female and infant mortality rates. FsQCA is a cross-case analytical method which enables logical statements to be made about the combinations of causal conditions that are sufficient for an outcome. This analysis finds that seven combinations of causal conditions are sufficient for changes in adult female and infant mortality rates. These findings are further investigated through in-depth case study work using process tracing methods. Process tracing results suggest that the worsening of adult female mortality rates is related to T&C workers' lack of labour market and welfare state protections.

57145

**(UN)EMPLOYMENT AND MENTAL HEALTH CARE USE ASSESSED BY MACRO-SOCIOECONOMIC CONTEXT AND CHANGE INFLUENCES**

*Veerle Buffel*

*Vera van de Straat*

*Piet Bracke*

University of Ghent, Belgium

**INTRODUCTION:** To date, little research has investigated whether the relationship between individual socio-economic determinants and mental health care use varies across macro-economic conditions and gender. Given the current economic crisis, these questions are increasingly relevant, particularly when the relation between employment status and mental health care use is concerned. **Objectives –** We investigate professional care use for mental health problems of the unemployed versus the employed in Europe by assessing the impact of macro-economic context and changes herein. The following theoretical perspectives will be tested: provocation mechanisms (mental health mediates the relation between economic context and professional care seeking) versus alternatives, who argue for a direct relation (prophylactic care use, medicalization, uncovering- and shift hypothesis). We also pay attention to age and gender differences. **METHODS:** Logistic three-level analyses are performed using a subsample of 22978 men and 28014 women of working age from three waves of the Eurobarometer; 58.2 (2002), 64.4 (2005) and 73.3 (2010). Contacting a general practitioner (GP) and a psychiatrist for mental health problems are the main dependent variables.

**RESULTS AND CONCLUSIONS:** Macro-economic conditions seems to have an direct impact on the professional care seeking of men, while for women this impact was mediated by their need for care. In addition, the higher mental health care use among the unemployed, compared to the employed, was more pronounced among younger men. The results of both men and women give evidence for the medicalization of unemployment hypothesis. Especially men exert tendencies to medicalize their problems during economic contraction, characterized by a steep increase of unemployment rates.

**Session 4B: HEALTH CARE III: Use of health care**

**Chair: Sakari Karvonen, National Institute for Health and Welfare (THL), Finland**

59232

**SOCIOECONOMIC PATTERNS IN USE OF PRIVATE AND PUBLIC HEALTH SERVICES IN SPAIN, 1987-2007**

*Lourdes Lostao*

Universidad Pública de Navarra, Spain

**INTRODUCTION:** The coexistence of public and private health services raises the difficulty of comparing the achievement of equity between countries when studying all health services, without differentiating between public and private. The objective of this study is to evaluate the pattern of private and public physician visits and hospitalization by socioeconomic position in two periods, 1987-2007.

**METHODS:** The data were taken from the 1987 and 2006 National Health Survey carried out by the Ministry of Health and the National Statistics Institute. The two health services investigated were public and private specialist visits and hospitalisation. The measure of socioeconomic position was the socioeconomic group based on the occupation of the reference person in the household. The measure of the association between use of services and the socioeconomic position was the age, sex and morbidity-adjusted odds ratio.

**RESULTS:** No significant socioeconomic differences were observed in public hospitalization in both periods, but the use of public specialist visits was higher in the worst off. The odds ratio in the use of private health services in the best off with respect to all the other socioeconomic groups was around 2.5 higher in the two types of health services in both periods.

**DISCUSSIONS:** The pro-poor horizontal equity in the use of public specialist visits in Spain could represent an overuse of public health services by low socioeconomic groups or could be due to the fact that persons in high socioeconomic positions preferably choose to use private health services

56943

## HOW DO CHANGES IN PERSONAL INCOME AFFECT USE OF PRIVATE HEALTH CARE IN FINLAND?

*Jenni Blomgren*

Research Department, The Social Insurance Institution of Finland, Finland

**INTRODUCTION:** Based on previous studies, it is known that those with higher income use private health care more often than those with lower income in Finland. However, previous results are based on cross-sectional data, and it is not known to what extent changes in personal income affect the probability of using private health care. This study aims to assess the influence of income on use of private health care in working-age population.

**METHODS:** For a 30% sample of Finnish women and men aged 25–64, register data on health insurance compensation paid for using private health care were linked to population data and data on yearly taxable gross income of the individuals for years 2006–2011. Fixed effects logistic panel regression models, that automatically control for all time-invariant characteristics of the individuals, were used to model the probability of using private doctor care and private examination and treatment during the year.

**RESULTS:** Increase in personal income increased the odds of using private care statistically significantly but the estimates were rather small. Among women, adjusted for changes in covariates (age, drug reimbursement rights, region and municipality type), the odds of visiting a private doctor at least once per year increased by 1.3% and the odds of receiving private examination and treatment increased by 1.5% per one thousand euros' increase in yearly income. Among men, the increase in odds was 0.3% and 0.8%, respectively.

**CONCLUSIONS:** Change in personal income has only a meagre influence on using private health care in Finland.

57027

## SOCIAL INEQUALITY IN UTILIZATION OF OUTPATIENT PSYCHOTHERAPY

*Jelena Jaunzeme*

*Denise Muschik*

*Siegfried Geyer*

Medical Sociology, Hannover Medical School, Germany

**INTRODUCTION:** In Germany outpatient psychotherapy is accessible to every member of statutory health insurance, suffering from one or several specific mental health problems. However, differences in utilization of outpatient psychotherapy can be assumed, resting upon educational and social status of an insured person. Several survey-based studies show increased utilization of care services for women with mental health problems as well as for persons aged 50–65. No response-independent secondary data-based studies are known which analyze the utilization of outpatient psychotherapy.

**METHODS:** Secondary data from a statutory health insurance company in Lower Saxony (Germany) is used for the analyses (N = 1'987'707). Data on utilization of outpatient health care services as well as insurance duration data are available. Utilization rates for 2011 are computed with stratification for gender, age, and qualification.

**RESULTS:** 75% of all insured persons, using outpatient psychotherapeutic services, are women. The utilization of outpatient psychotherapy is at its maximum for women in the age group 31 to 35 years and for men in the age group 36 to 40. Analyses on the qualification show that insured with an academic background as well as persons with 13 years of school education and completed vocational training are highly overrepresented as users of outpatient psychotherapeutic services.

**CONCLUSIONS:** Social inequality in utilization of outpatient psychotherapeutic services could be found based on analyses of qualification of the insured. Income from paid work or pensions will be added into analyses. Logistic regression models will be used to estimate the influence of different sociodemographic factors on utilization of outpatient psychotherapeutic services.

## **Session 4C: Pre-organized session: Physical activity – social determinants and consequences I**

**Organizer and chair: Tomi Mäki-Opas, National Institute for Health and Welfare (THL), Helsinki, Finland**

**57926**

### **OFF THE BEATEN PATHS**

*Thomas Abel*

University of Bern, Switzerland

This presentation will provide a focused introduction to the theme of the session. I will briefly introduce a conceptual perspective that shows the need for innovation in public health research if it wants to significantly advance our understanding of the social determinants and social consequences of physical activity. The introduction will also present some lines of thought meant to structure and facilitate exchanges of ideas and experiences of the session participants. The conceptual perspective I will present is based on a critical appraisal of established social epidemiology-based approaches to the study of physical activity and health. It will draw attention to ‘the risks of the risk factor approach’ and show where social science thinking and measurement can make a profound difference and can go beyond adding evidence to the traditional models of physical inactivity as a risk factor for a multitude of diseases. Examples from own most recent empirical analyses will help to illustrate the major conceptual ideas. The perspective from the introduction will then serve as a frame work to accommodate and link the single contributions of the session and facilitate a joined discussion among presenters and the audience. The introduction paper, together with the papers presented, will convey the main message of the session: There is much to discover and real progress is achieved when we draw more on sociological theory and apply innovative methods to study how physical activity affects health and society.

**56907**

### **ENVIRONMENTAL DETERMINANTS FOR COMMUTING PHYSICAL ACTIVITY IN FINLAND**

*Tomi Mäki-Opas<sup>1</sup>*

*Katja Borodulin<sup>1</sup>*

*Heli Valkeinen<sup>1</sup>*

*Sari Stenholm<sup>1, 2</sup>*

*A.E. Kunst<sup>4</sup>*

*T. Abel<sup>5</sup>*

*Tommi Härkänen<sup>1</sup>*

*Teppo Juntunen<sup>1</sup>*

*L. Kopperoinen<sup>3</sup>*

*P. Itkonen<sup>3</sup>*

*Ritva Prättälä<sup>1</sup>*

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**INTRODUCTION:** Attractiveness for commuting physical activity might vary depending on whether one lives near green space, water areas or cycling zones, but the scientific evidence is inconsistent. The aim of this study is to examine whether a) the proximity of green space and water areas as well as b) the location within urban pedestrian zone are associated with commuting physical activity among Finns.

**METHODS:** Nationally representative sample of 10,000 persons, the Health 2011 –study with self-reported information on commuting physical activity (n=4 322), sociodemographic factors, lifestyles and diseases were utilized. Green space, water areas, urban pedestrian zone and urbanization level were linked from Geographical Information Systems (GIS). Spatial analyses (raster analyses and Euclidean distance) were

conducted with ArcGIS 10.1 and statistical analyses using logistic regression with STATA 11.2 (odds ratios; 95% confidence intervals).

**RESULTS:** Proximity of green space (<200m) was associated with increased commuting physical activity (2.00; 1.37-2.91) as compared to those living further away from green areas. The association remained significant after adjusting for sociodemographic factors and chronic diseases (1.97; 1.34-2.90) as well as for urbanization level (1.52; 1.03-2.25). Access to water areas ( $\geq 300\text{m}$ ) had a positive (1.33; 1.10-1.61) whereas location in pedestrian zone not associated (1.20; 0.91-1.59) with commuting physical activity.

**CONCLUSIONS:** Green space and water areas in home neighborhood may have a positive role on commuting physical activity. Use of GIS-data should be encouraged when studying the social determinants for physical activity.

**50173**

### **AN INTERSECTIONAL APPROACH TO INEQUALITIES IN PHYSICAL ACTIVITY BY RACE, GENDER, CLASS AND SEXUALITY**

*Gerry Veenstra*

University of British Columbia, Canada

**INTRODUCTION:** Physical activity is socially stratified in Canada. To date, inequalities in physical activity by race or ethnicity, gender, class or sexual orientation, in Canada and elsewhere, have largely been investigated as distinct, additive phenomena. Informed by intersectionality theory, this paper examines the degree to which and how 'race,' gender, class and sexuality 'intersect' with one another to predict physical activity in Canada.

**METHODS:** Using data from Cycles 2.1 and 3.1 of the Canadian Community Health Survey (n=149,574), we regress 'race,' gender, education, household income and sexual orientation on an index of physical activity, first examining the main effects of the independent variables and then examining two-way and three-way interactions between them.

**RESULTS:** The principle of multiplicativity suggests that people's experiences of their gender identities are raced, classed and sexualized, their racial experiences are gendered, classed and sexualized, and so forth. We find that the positive effect of income on being physically active is strong among visible minority men, of moderate strength among White men and women, and weak to non-existent among visible minority women. We also find that a non-heterosexual orientation corresponds with a greater likelihood of being physical active among women (especially among less-educated women) but not among men.

**CONCLUSIONS:** These 'multiplicative' findings undermine the established approach to investigating social inequalities and physical activity and pave the way for future intersectional analyses of axes of inequality and their diverse, intersecting effects.

**56940**

### **LEISURE-TIME PHYSICAL ACTIVITY AND MORTALITY**

*Jouni Lahti*

*Anna-Leena Holstila*

*Eero Lahelma*

*Ossi Rahkonen*

Hjelt Institute, Department of public health, University of Helsinki, Finland

**INTRODUCTION:** Physical inactivity is associated with increased risk of mortality. It is, however, poorly understood whether vigorous physical activity is more beneficial than activities of lower intensity. The aim of this study was to examine associations of the intensity and volume of leisure-time physical activity with mortality among middle-aged women and men.

**METHODS:** Questionnaire survey data collected in 2000-02 among 40-60-year-old employees of the City of Helsinki (N = 8960) were linked with register data on mortality (74% gave permission to the linkage). Mean follow-up time was 12-years. The analysis included 6429 respondents (79% women). The intensity was classified into three groups: low moderate, high moderate and vigorous. The volume of physical activity (MET-hrs/wk) was classified into three groups using tertiles as cut-points. Key sociodemographic and health related factors were included as covariates. Cox regression analysis was used to calculate hazard ratios (HR) and 95% confidence intervals (CIs) for mortality.

**RESULTS:** Of the participants 205 died during the follow-up. Compared with the low moderate group the vigorous group (HR=0.53, 95% CI 0.33-0.85) had a reduced risk of mortality after adjusting for



confounders whereas for the high moderate group the association (HR=0.71, 95% CI 0.47-1.06) was less clear. Adjusting for the volume of physical activity did not affect the point estimates. Higher volume of physical activity was also associated with reduced mortality risk; however, adjusting for the confounders and the intensity of physical activity explained the differences.

**CONCLUSIONS:** Higher intensity leisure-time physical activity may be important for preventing premature deaths.

#### **Session 4D: Pre-organized symposium: Undoing psycho-patologisation** **Organizer and chair: Elizabeth McDermott, Lancaster University, UK**

**53454**

##### **‘GENUINE’ OR A ‘CRY FOR HELP’? GENERAL PRACTITIONER’S ACCOUNTS OF TREATING SELF-HARM**

*Amy Chandler*

University of Edinburgh, UK

**INTRODUCTION:** There are on-going debates around self-harm and suicide in terms of nosology, and the extent to which they are related – or not. Limited attention has been paid to the ways that medical practitioners negotiate these complexities when treating patients who have self-harmed.

**METHODS:** This paper draws on qualitative, semi-structured interviews with 30 General Practitioners (GPs) working in Scotland, UK. The sample was balanced in terms of: gender, age, experience, practice location (urban/rural, deprived/affluent). GPs were asked to reflect on their understandings of self-harm and their experiences of treating patients who had self-harmed, including how they assessed suicide risk. Self-harm was defined by GPs themselves. Analysis was thematic, informed by a narrative approach to the data.

**RESULTS:** This paper examines the ways in which both gender and age of patients featured in the accounts GPs provided. In some interviews, self-harm by certain categories of person (young, female) was framed as ‘less serious’, or ‘less genuine’. Assessments as to whether self-harm was ‘serious’ were closely tied to perceptions about the risk of suicide posed by individual patients. Thus, self-harm that was deemed ‘non-suicidal’, carried out by younger and/or female patients was often constructed as relatively unproblematic.

**CONCLUSIONS:** In some cases GPs appeared to work hard to avoid pathologizing self-harm, at least among some patients. However, this may have deleterious effects. Self-harm that was framed as non-pathological might be dismissed and its significance minimized leading to frustrated attempts, by young people especially, to seek help for self-harm and related problems.

**57221**

##### **EMBODYING DISTRESS: EMOTIONAL AND RELATIONAL WORK DONE BY LGBTQ YOUTH WHO SELF-HARM**

*Katrina Roen*

Department of Psychology, University of Oslo, Norway

**INTRODUCTION:** Young people can find themselves under significant pressure to be ‘happy’ and ‘successful’, as well as to conform to sexuality and gender norms. This paper examines the corporeal and discursive effects for those who feel distressed, feel they have failed, and are navigating a path outside of norms.

**METHODS:** Qualitative data were drawn from online forums where LGBTQ (lesbian, gay, bisexual, trans, or queer) youth describe their own distress and self-harming. The analysis takes a discourse analytic perspective. I examine what kinds of relationships and what kinds of agency become possible, according to the ways of relating that are discussed by LGBTQ youth writing online about self-harm.

**RESULTS:** The centrality of connection and disconnection, intimacy and isolation is clear in the data. One of the threads running through the data – and particularly the advice young people give one another online – suggests that it may be possible and worthwhile to distance oneself from significant others and keep quiet about the things that are important or distressing (i.e., sexuality, gender identity, self-harm).

**DISCUSSION:** Discourses of individualism and interiority make it plausible that one can be a bounded, self-sufficient subject, keeping hidden anything that would disrupt the normative fabric of family and school. Developmental and neoliberal discourses suggest that it will only be a matter of time before one can come out and live as an autonomous, out, proud, happy queer adult subject. ‘It gets better’, youth are told



by numerous online contributors. This paper examines how embodied distress features in the lives of LGBTQ youth while they wait for 'it' to 'get better'.

**57275**

**'IT'S JUST HORMONES': HELP-SEEKING, SELF-HARM AND LGBT YOUTH**

*Elizabeth McDermott*

Lancaster University, UK

International evidence suggests that young people are less likely to seek help for mental health problems in comparison to adults. This study focussed on lesbian, gay, bisexual and trans (LGBT) young people who are a population group with an elevated risk of suicide and self-harm, and little is known about their help-seeking behaviour. Utilizing qualitative virtual methods, LGBT youth web-based discussions about seeking help for suicidal feelings and self-harming were investigated. The sample included those who had not contacted services. Findings from a thematic analysis indicate these young people wanted assistance but found it difficult to: i) ask for help; ii) articulate emotional distress; iii) 'tell' their selves as 'failed'. This analysis suggests that key to understanding these problems are emotions such as shame which arise from negotiating norms connected to heterosexuality, adolescence, and rationality. I argue that these norms act to regulate what emotions it is possible to feel, what emotions it is possible to articulate, and what type of young lives that can be told. The future development of health and social care interventions which aim to reduce LGBT youth suicide and self harm need to work with a nuanced understanding of the emotional life of young people if they are to be effective.

**Session 4E: HEALTH POLICY AND SERVICES III**

**Chair: Jon Ivar Elstad, NOVA, Oslo and Akershus University College, Norway**

**56753**

**AVOIDABLE HOSPITALIZATION RATES IN NORWAY – EQUAL FOR IMMIGRANTS AND NATIVES?**

*Jon Ivar Elstad*

*Jon Erik Finnvd*

NOVA, Oslo and Akershus University College, Norway

**INTRODUCTION:** The increasing ethnic diversity in Norway constitutes a challenge for the health services. In 2013, 14 per cent of the Norwegian population were immigrants; more than half of them from non-Western countries (Pakistan, Iraq, Vietnam, Somalia, etc.). The purpose of this paper is to compare hospitalization rates among natives and main immigrant groups, with a particular emphasis on Avoidable Hospitalizations (AH), ie., admissions which, in many cases, could have been prevented through adequate use of municipal health services and effective self-care. AH conditions include chronic diseases such as asthma, diabetes, and some CVD conditions, and acute conditions such as pneumonia and dehydration. High AH rates could possibly indicate a need for upgrading access and quality of the primary health services.

**METHODS:** Register information on all somatic hospital admissions 2008-2011 (ca. 3 million admissions, ca. 1.4 million individual patients) in the Norwegian Patient Register has been linked to Statistics Norway's register information on the entire Norwegian population in 2008 (ca. 4.8 million inhabitants), by means of the personal identification number. Hospital admissions, acute and planned, were classified according to diagnosis and further classified into AH and non-AH. Number of somatic hospital admissions, number of days in somatic hospital 2008-2011, and rates of AH and non-AH among natives and immigrant categories are analyzed, using age, gender, education, etc. as covariates.

**RESULTS AND CONCLUSIONS:** As data were not available until February 24, 2014, final results cannot be presented in this abstract. Preliminary age-adjusted analyses suggest that immigrants overall (ie., including Western immigrants) have lower hospitalization rates than natives, while the proportion of AH of all hospitalization were fairly similar for natives and immigrants.

57142

**WHY WERE THEY ADMITTED? EXPLORING HOSPITAL ADMISSIONS OF PATIENTS CLOSE TO THE END OF LIFE**

*Sarah Hoare*

*Mike Kelly*

*Stephen Barclay*

University of Cambridge, UK

**INTRODUCTION:** Hospital admissions for UK patients close to the End of Life (EoL) patients are labelled in NHS policy as avoidable and inappropriate and denigrated as expensive and contrary to public choice. To tackle these admissions policy suggests a 'pathway' of measures. Dying patients should be; identified, discussed regularly by multi-disciplinary teams, asked their preferences for EOL care and have services coordinated to meet their preferences. However, EOL patients are still being admitted to hospital and are still dying in hospital.

**METHODS:** Drawing on literature from organisational sociology, I will be discussing the extent to which policy describes dying as a linear, mechanical process has implications for hospital admissions of EOL patients. I will present initial results from a retrospective study at two UK hospital sites. "Clusters" focused on a patient who had died within 3 days of admission, with interviews with up to five practitioners who were involved in the admission and one next of kin.

**RESULTS:** Interviewees found dichotomising hospital admissions as inappropriate or appropriate was unhelpful in distinguishing between admissions. Healthcare practitioners' accounts of their involvement in dying depict a messy, complicated 'spaghetti' reality that is far removed from the neat one way pathway presented in EOL policy.

**CONCLUSIONS:** Analysis is ongoing but I propose that practitioners view of dying as EOL 'spaghetti' may reflect a disjuncture between policy and practice over any inherent complexity in the dying process. The research has implications for how policymakers and practitioners perceive and organise end of life care.

55696

**INFORMALITY IN HOSPITAL ORGANIZATIONS - OBSTACLE OR MOTOR? RESULTS FROM NINE NORTHEASTERN GERMAN HOSPITALS**

*Thomas Elkeles<sup>1</sup>*

*Maria Crojethovic<sup>2</sup>*

*Sebastian Gütschow<sup>1</sup>*

*Carolin Krüger<sup>1</sup>*

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<sup>1</sup>University of Applied Sciences Neubrandenburg, Germany

<sup>2</sup>University of General Sarmiento, Argentina

**INTRODUCTION:** Informal aspects can contribute to achieve or to impede the organizational goals of an institution. Informality is an overall phenomenon in all institutions. In Germany, an ongoing process of economization has developed within hospitals what corresponds to several problems in work organization. Therefore problems, situations and/or challenges which tend to informal actions and types of non-regulated initiatives should be analyzed.

**METHODS:** We chose a triangulation of quantitative and qualitative methods. 338 questionnaires were responded and 20 interviews with physicians and nursing personnel were conducted in nine Northeast German hospitals 2011/2012 accompanied by content analyses of documents.

**RESULTS:** In addition to the quantitative results – many of them concerning the lack of staff – we identified various types of initiatives: legal, illegal and precarious. Many aimed to solve the problem of deficiency in the staff and of communication between professional groups. Bottom-up-initiatives were more frequent than top-down-initiatives. Often only short term solutions to organizational problems were found.

**CONCLUSIONS:** Short term initiatives in our hospitals appear to be an instrument of reproduction of the institutionalized order rather than the initiation of organizational change. In order to achieve the organizational goals, informality must be developed as an organizational instrument and not let to the responsibility of the lower hierarchical positions. Thus, it must be discussed further what formality and informality mean and how, and under which conditions this influences the organizational dynamic.

56900

**WHEN HEALTH SERVICE CONTRIBUTES TO HEALTH INEQUALITIES: THE CASE OF GYNECOLOGICAL CANCERS SCREENING IN FRANCE**

*Géraldine Bloy*<sup>1</sup>

*Laurent Rigal*<sup>2</sup>

<sup>1</sup> University of Burgundy/CNRS, France

<sup>2</sup> Family Practice Department, Paris-Descartes University, France

Considering the case of gynecologic cancers screening, we intend to analyze the genesis of health inequalities in relation to health service organization. Screening status was analyzed according to socioeconomic status among a random sample of 1819 women with logistic mixed models. We observed marked social gradients for cervical cancer, but lower ones for breast cancer for which an organized screening programme alongside the individual one exists. However, the last prescriber was socially differentiated: gynecologists for the upper class, organized screening for the lower and General Practitioners (GPs) for the middle. The modeling role of the healthcare system in producing inequalities through social norms it contributes to establish can be specified. Organized screening contributes to catch up patients with low social status. Gynecologists often ask for unregulated fees and receive patients with good socioeconomic level, whom they tend to overscreen. GPs are supposed to have a gatekeeper function toward specialists, but direct access to gynecologists is possible without referral. Although GPs involvement would be necessary to improve participation and lower inequalities, they lack legitimacy and tend to divest of these screenings. In addition to this suboptimal task division, information sharing and coordination between professionals are limited. This confusing situation has been settled by socio-historical processes, without any global vision of the interactions and perverse effects it would induce. Despite the pressure on health funding and the bad demographic perspectives, it seems difficult in the French context to remodel professionals' routines or to re-regulate the screening of women on more equal basis.

**Session 4F: YOUNG PEOPLE I: inequalities and life-course**

**Chair: Laura Kestilä, National Institute for Health and Welfare (THL), Helsinki, Finland**

59446

**EDUCATIONAL SYSTEMS AND HEALTH INEQUALITIES AMONG YOUNG PEOPLE: A MULTILEVEL ANALYSIS IN 34 COUNTRIES**

*Katharina Rathmann*

Medical Faculty, Institute of Medical Sociology, Martin-Luther-University Halle-Wittenberg, Germany

**INTRODUCTION:** Cross-national studies have shown that macro-level factors, such as national income or income inequality are important determinants of health and social disparities in health. Comparative research has rarely focused on features of educational systems as structural determinants of health and health inequalities. Thus, the aim of this study is to investigate whether characteristics of the educational system (i.e. public, private and preschool sector, and educational differentiation) are driving forces of social inequalities in adolescent subjective health.

**METHODS:** Data were collected from the Health Behaviour in School-aged Children (HBSC) study in 2006, which included 11- to 15-year old adolescents from 34 European and North American countries (n=159,824). Social position was measured by the family affluence scale. Logistic multilevel models were conducted in order to test the impact of features of the educational system (i.e., expenditures and size of public, private and preschool sectors as well as differentiation and segregation) and social disparities in psychological health complaints.

**RESULTS:** The multilevel results showed that particularly a large private preschool sector and high public expenditures on education were associated with a lower degree of social inequalities in psychological health complaints, whereas adolescents in countries with an educational system that is characterized by a high extent of segregation showed greater inequalities in psychological health complaints.

**CONCLUSIONS:** This study provides first evidence on the relationship between characteristics of the educational system and social disparities in young people's health. The results enable to provide first implications for policy and practice.

**56934**

**SOCIAL INEQUALITIES IN ADOLESCENT HEALTH COMPLAINTS FROM 1994-2010:  
INTERNATIONAL TRENDS FROM THE HBSC STUDY**

*Irene Moor*

Institute of Medical Sociology, Martin-Luther-University Halle, Germany

**INTRODUCTION:** Studies have shown consistent or increasing health inequalities in adulthood in the last decades. So far, little is known about trends in health inequalities among children and adolescents. The aim is to analyse changes in socioeconomic differences in subjective health complaints from 1994 to 2010 among 11- to 15-year-olds in Europe, North America and Israel.

**METHODS:** Data were obtained from the international WHO-collaborative "Health Behaviour in School-aged Children" (HBSC) survey in 1994, 1998, 2002, 2006 and 2010. Log binomial regression models were used to assess inequalities in multiple health complaints. Socioeconomic position was measured using perceived family wealth.

**RESULTS:** Inequalities in multiple health complaints were identified in almost all countries in particular since 2002. Trend analyses showed stable (29 countries), increased (5 countries), decreased (one country) and no social inequalities (2 countries) in health complaints.

**CONCLUSIONS:** In almost all European and North American countries, social inequalities in health complaints remained consistent over a period of up to 16 years. Our findings suggest a need to intensify efforts in social and health policy to tackle these existing inequalities.

**57202**

**CHANGES IN HEALTH BEHAVIOR AMONG RUSSIAN YOUTH DURING COUNTRY'S  
TRANSITION**

*Anastasiya Verho*

*Tiina Laatikainen*

*Erkki Vartiainen*

National Institute for Health and Welfare (THL), Helsinki, Finland

**INTRODUCTION:** Russia faced significant politic and economic changes and world-famous for the highest CVD in the world. Health behaviors develop early in life, shaped by environmental influences and difficult to change. The study investigates changes in health behavior among Russian youth during the country's transition in 1995 and 2004.

**METHODS:** Behavioral CVD risk factors studied using an internationally comparable methodology among 780 (385 in 1995, response 95% and 395 in 2004, response 85%) 15 y.o students, from all schools of Pitkäranta district in the Republic of Karelia in 1995 and 2004. Questionnaire with precoded answers including 7/day recall was used. Changes in prevalence rates were assessed by Chi-square test.

**RESULTS:** During study period daily smoking doubled among girl. Tobacco and alcohol are easy accessible. Gender differences in alcohol consumption have diminished. Number of youth never tried alcohol decreased twice. Weekly alcohol drinking increased among both genders. Beer consumption among girls has tripled. Both: vegetable, fruit and berry consumption together with purchasing food/drinks high in saturated fat and sugars have increased. Nutritional literacy was rather low and further decreased among both genders. Reported changes were statistically significant.

**CONCLUSIONS:** Country's transition has an effect on health behavior of Russian youth. With regard to some positive changes, negative changes prevail in health behavior of adolescents. Public health interventions and health policy changes are needed to improve health behavior of Russian youth.

57267

**IS BEING A “SMALL-FISH-IN-A-BIG-POND” BAD FOR STUDENT HEALTH? CLASSMATES’ ACHIEVEMENT-LEVEL AND SUBJECTIVE HEALTH IN GERMANY**

*Katharina Rathmann*

Medical Faculty, Institute of Medical Sociology, Martin-Luther-University Halle-Wittenberg, Germany.

**INTRODUCTION:** The academic achievement in classrooms has often been subject of prior research in relation to students’ academic outcomes or self-concept (Big-Fish-Little-Pond-Effect). However, evidence in relation to health outcomes of students is limited, so far. Thus, this is the first study investigating whether and how achievement composition in classrooms affects subjective health outcomes and varies between high- and low-resource (in terms of individual achievement and socioeconomic position) secondary school students in Germany.

**DATA AND METHODS:** Data were derived from the German sample of the WHO-Collaborative “Health Behaviour in School-aged Children (HBSC)” study 2005/2006, including 3.623 11-, 13- and 15-year-old students in secondary schools. Average academic achievement in class was generated by aggregating individual achievement at the class-level. The varying sensitivity to classrooms achievement-level was measured by students’ individual academic achievement and socioeconomic position, measured by the Family Affluence Scale (FAS). Using logistic multilevel regression models, the association between class-level academic achievement and individual subjective psychosomatic health complaints, self-rated health and life satisfaction were analysed, stratified for differences between high and low resource students.

**RESULTS:** The logistic multilevel results showed that higher academic achievement in classrooms was significantly associated with psychosomatic health complaints, but not with self-rated health and life satisfaction. Further, the impact of classrooms’ achievement levels on health complaints varied by family affluence, but not by student’s individual academic achievement, indicating that high affluent students had higher likelihoods of psychosomatic complaints in classrooms with higher extents of high-achieving students compared to low affluent students.

**CONCLUSIONS:** This study adds first evidence on the so-called contrast effects by linking the level of academic achievement within classrooms and adolescents’ subjective health outcomes as well as differential effects for high and low resource students in Germany. Further research is needed in order to receive reliable results in relation to young peoples’ health.

**Session 4G: GENDER AND HEALTH III**

**Chair:** Zofia Slonska, Instytut Kardiologii, Poland

57241

**DO INDIAN GIRLS FACE A NUTRITIONAL DISADVANTAGE? GENDER DISPARITIES IN BREASTFEEDING AND FOOD CONSUMPTION**

*Jasmine Fledderjohann*

University of Oxford, UK

**INTRODUCTION:** India is the only nation where girls have greater risks of under-5 mortality than boys. We analyze whether female disadvantage in breastfeeding and food allocation can account for gender disparities in under-five mortality rates.

**METHODS:** Multivariate regression and Cox models were performed for first- and secondborn children aged 0-59 months (n=20,395) using Round 3 of India’s National Family and Health Survey 2005-2006. Models were disaggregated by birth order and sibling gender, and adjusted for maternal age and education, maternal fixed effects, urban residence, household deprivation, and other sociodemographics. Outcomes: Mothers’ reported adherence to WHO/UNICEF recommendations for breastfeeding initiation, exclusivity, and total duration, children’s consumption of 24 individual food items (ages 6-59 months), and child survival (0-59 months).

**RESULTS:** Girls were breastfed on average for 0.45 months less than boys (95% CI: = 0.15 to 0.75,  $p = 0.004$ ). However, there was no gender difference in the likelihood of breastfeeding initiation (OR = 1.04, 95% CI: 0.97 to 1.12) or exclusive breastfeeding (OR = 1.06, 95% CI: 0.99 to 1.14). Differential risk of breastfeeding cessation emerged between ages 12 and 36 months in secondborn females. Compared with boys, Indian girls consumed less fresh milk by 14% (95% CI: 79% to 94%,  $p=0.001$ ) and breast milk by 21% (95% CI: 70% to 90%,  $p<0.000$ ). Each additional month of breastfeeding duration was associated with



a 24% lower risk of mortality (OR=0.76, 95% CI: 0.73 to 0.79,  $p<0.000$ ). Girls' shorter breastfeeding duration accounted for about an 11% increased probability of dying before age 5, accounting for about one-half of their survival disadvantage compared with other low-income countries.

CONCLUSIONS: Indian girls are breastfed for shorter periods than boys and consume less fresh milk. Future research is needed to investigate the role of alternative factors driving India's female survival disadvantage, such as inequitable healthcare access.

**57251**

**WOMEN AS MOTHERS AND NURTURERS: UNRAVELING THE RELATIONSHIP BETWEEN GENDER EQUALITY, EDUCATION AND BREASTFEEDING (BELGIUM)**

*Karen Vanderlinden*

*Bart Van de Putte*

Department of Sociology, Ghent University, Belgium

INTRODUCTION: Even though breastfeeding is typically considered the preferred feeding method for infants worldwide, in Belgium breastfeeding duration rates remain low across several native and migrant groups while the underlying causal mechanisms are unclear. Furthermore, research examining the context mothers grew up in, especially regarding gender equality and ideology, is rare. Objective: For both natives and migrants we first assess whether gender equality in the country of origin influences feeding choice. Second, we compare the importance of the context of gender equality in the country of origin with the mother's individual educational level for determining feeding choice.

METHOD: Based on population data of nearly all new borns in Belgium (Flanders) in 2004 (N=34314), we perform binary logistic analyses. Feeding method is indicated by exclusive breastfeeding 3 months after childbirth. We measure gender equality using Global Gender Gap scores from the mother's country of origin. The mother's educational level is categorized into 4 categories. Controls are birth weight, birth length, baby's sex, maternal age, ethnicity and child's parity.

RESULTS: Results initially show a strong positive effect of gender equality on breastfeeding. However, this effect is wiped out when adding the mother's level of education. There is strong between-category variation regarding the mother's level of education.

CONCLUSIONS: We see that the mother's education, at the individual level, is a stronger predictor of breastfeeding chances than gender equality. This does however not preclude an effect of gender equality. Gender equality can influence a mother's educational level, which in turn determines breastfeeding chances. Discussion: Possible explanations are discussed in-depth setting direction for future research regarding gender equality and breastfeeding.

**56953**

**RE-EMBODYING ULTRASOUND: WOMEN'S ACCOUNTS OF FETAL SONOGRAMS PRIOR TO ABORTION IN ENGLAND**

*Sian M. Beynon-Jones*

Department of Sociology, University of York, UK

INTRODUCTION: The practice of visualising the fetus via obstetric ultrasound has been subject to several decades of detailed feminist scholarship. Concerns have been raised about the treatment of ultrasound images as an 'objective' source of knowledge about the fetus, an approach which erases women and their embodied knowledge from the 'picture' of pregnancy. In response, feminist analyses have highlighted the situated practices via which particular interpretations of these images are sustained – including by pregnant women themselves. This paper contributes to this project by exploring women's accounts of fetal ultrasound in a novel healthcare context: abortion provision.

METHODS: Fetal ultrasound is routinely performed as part of abortion care in England, as a means of dating women's pregnancies, and checking for multiple or ectopic pregnancies. This paper draws on qualitative interview data (n=23) concerning women's experiences of pregnancy and abortion in England, and analyses the discourses via which women construct the experience of ultrasound in this context.

RESULTS: The women interviewed for this study constructed a dominant cultural script about fetal ultrasound, describing it as a set of practices associated with a particular set of 'feeling rules', namely, excitement at meeting and welcoming a wanted baby. As a consequence, many found it difficult to negotiate and narrate the experience of ultrasound as part of the process of ending a pregnancy. At the same



time, women's accounts offer a series of challenges to the dominant script via the ways in which they re-embodiment and re-situate the experience of ultrasound.

CONCLUSIONS: The interview data highlight the ongoing importance of problematizing hegemonic discourse concerning fetal ultrasound, and provide alternative ways of conceptualising this practice.

## **PARALLEL SESSIONS V**

### **FRIDAY 29 August at 10.20 - 11.50**

#### **Session 5A: Pre-organized session: Recession and health in Europe II: Macro-economic change and health**

**Organizer and chair: Tim Huijts, University of Oxford, UK**

**57257**

#### **DO SICKNESS BENEFIT ARRANGEMENTS BUFFER AGAINST THE HEALTH RISKS OF HAZARDOUS WORK AND LOW EDUCATION?**

*Kjetil A. Van der Wel*<sup>1</sup>

*Nico Dragano*<sup>2</sup>

*Thorsten Lunau*<sup>2</sup>

*Terje Eikemo*<sup>3</sup>

*Clare Bambra*<sup>4</sup>

<sup>1</sup> Faculty of Social Sciences, Oslo and Akershus University College of Applied Sciences, Norway

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<sup>3</sup> Department of Sociology and Political Science, Norwegian University of Science and Technology, Norway

<sup>4</sup> Department of Geography, Wolfson Research Institute for Health and Wellbeing, Durham University, UK

INTRODUCTION: Recent research suggest that generous social protection might have beneficial effects on employment and health. Therefore, in this article, we ask whether the level of sickness benefit provision may protect the health of employees, particularly those who are most exposed to hazardous working conditions and those who have a lower education.

METHODS: The study uses the European Working Condition Survey 2010, with information on 20626 individuals in 28 countries. Health was measured by mental well-being and self-rated general health. Sickness benefit provision was constructed using spending data from Eurostat. Group specific effects were fitted using cross-level interaction terms between sickness benefit provision and physical, chemical and psychosocial working conditions respectively, as well as low education.

RESULTS: Mental well-being of employees exposed to psychosocial job strain and physical hazards was higher in countries with more generous sickness benefit provision. The low education group seemed to benefit in the same way in terms of mental well-being. These results were similar for men and women and robust to the inclusion of GDP and country fixed effects. In the analyses of self-reported general health, few group specific associations were found.

CONCLUSIONS: This paper shows that mental well-being is better among high risk groups in countries characterised by generous sickness benefit provision. Also, social inequalities in mental well-being decrease considerably when sickness benefit provision is higher.

**59443**

#### **RECESSION AND ADOLESCENT HEALTH INEQUALITIES: DO SOCIAL BENEFITS BUFFER HEALTH INEQUALITIES IN THE “LOST GENERATION”?**

*Katharina Rathmann*

Medical Faculty, Institute of Medical Sociology, Martin-Luther-University Halle-Wittenberg, Germany

INTRODUCTION: The recent economic recession, has had a detrimental impact on health and supposedly on social disparities in health. Therefore, many OECD countries have increased social expenditures (e.g. family benefits) in order to guarantee social security for (young) people in need and to reduce social disparities. However, there is a dearth of studies which investigated the impact of social policy features on

health and social disparities in health among young people during the crisis. This study examines whether social benefits can ameliorate social disparities in health.

**METHODS:** Database is the WHO-collaborative 'Health Behaviour in School-aged Children' study in 2006 and 2010, which included 11- to 15-year old adolescents from 27 European and North American countries (n=153,712). Social position was measured by the family affluence scale (FAS). Logistic multilevel models were conducted to test the association of absolute rates of family benefits (2007 and 2010), as well as its change rate (between 2007 and 2010) and adolescent psychological health complaints in 2010, respectively.

**RESULTS:** Multilevel results showed that adolescents in countries with higher average levels of social benefits in 2007 (before the crisis) had greater inequalities in psychological complaints. For the relative change rate in family benefits (between 2007 and 2010), the multilevel analysis also revealed greater inequalities in psychological health complaints for adolescents with low and medium FAS compared to adolescents with high FAS as the relative change rate increased.

**CONCLUSIONS:** This study examined for the first time the impact of social benefits on social inequalities in adolescent health during the economic crisis. In contrast to our hypothesis, an increase in social benefits did not buffer social disparities in young people's health, indicating that increases in social benefits can not tackle social inequalities in adolescent health. Lastly, further research is strongly required.

**57738**

### **JOB LOSS AND HEALTH: THE MITIGATING EFFECT OF SOCIAL PROTECTION EXPENDITURE IN 23 EUROPEAN COUNTRIES**

*Tim Huijts*

University of Oxford, UK

**INTRODUCTION:** Because of the economic crisis, the question how the harmful effects of job loss on health can be mitigated has gained considerable relevance. We examine the impact of job loss on health in 23 European countries, during the first years of the economic crisis. Additionally, we examine whether expenditure on active labour market policies, unemployment benefits, and the total expenditure on social protection mitigate the harmful effect of job loss on health.

**METHODS:** We analyzed the longitudinal component of the European Union Statistics on Income and Living Conditions (EU-SILC), including data on individuals from 30 European countries. We compare one base year (2007) with two follow-up years (2009 and 2010). Health was measured by a general self-assessment. Information on expenditure on social protection policies was obtained from Eurostat. To analyze the data, multilevel logistic regression analyses were performed.

**RESULTS:** Preliminary results show that job loss between the base year and the follow up year is positively associated with reporting poor health in the follow up year, adjusting for all individual control variables (OR=1.66). We find only one significant cross-level interaction effect: for women, the effect of job loss on poor health is significantly stronger as expenditure on unemployment benefits is higher (OR=1.11).

**CONCLUSIONS:** Job loss is related to reporting poor health after a follow-up period of two or three years. Additionally, we find little support for the claim that increased expenditure on social protection policies would limit the harmful consequences of job loss on health in Europe during the economic crisis.

**59365**

### **ECONOMIC CRISIS, SOCIAL POLICY AND HEALTH INEQUALITIES: A SYSTEMATIC REVIEW OF THE RESEARCH LITERATURE**

*Espen Dahl*

Oslo and Akershus University College, Norway

**PURPOSE:** The purpose of the systematic review is to collect and review research that has examined how economic crises have impacted on population health and health inequalities and to which degree the welfare state has played a modifying role. Based on the available evidence the ambition is further to develop testable theories and hypotheses for the empirical analyses to follow. The review is part of a larger project funded by the Norwegian Research Council which will use comparative data sets to study the current downturn in Europe.

**BACKGROUND AND RESEARCH QUESTIONS:** We will draw from insights and findings from Brenner's earlier literature on business cycles and mortality and Ruhm's more recent studies. Also

experience from countries that have undergone deep crisis or transformations like Russia and other Eastern European countries will be scrutinized. Further, the experience of recessions in the two Nordic countries during the early 1990s, Sweden and Finland, will be examined, in particular the hypothesis that the welfare state was able to buffer the detrimental consequences of the economic downturn. Studies of the current recession by e.g. Stuckler and collaborators will certainly provide valuable material. In the review, we will try to identify the following dimensions of crises that we suspect will have an impact on the outcomes: What kinds of crisis are we facing, (economic, political, fiscal, social), what is the speed with which it has evolved, how has the state responded to meet the crisis, and what are the changes in social and health policy?

**METHODS:** We will comply with guidelines issued for instance by the Campbell collaboration by developing clear inclusion/exclusion criteria, having an explicit search strategy, and a systematic coding and analysis of included studies.

## **Session 5B: Pre-organized session: Informal caregiving I**

**Organizer and chair: Ellen Verbakel, Department of Sociology, Radboud University Nijmegen, Netherlands**

**53996**

### **‘ALERT ASSISTANTS’ AND ‘SUBSTITUTE PARENTS’: THE ROLE OF SIBLINGS IN THE MANAGEMENT OF CHILDHOOD EPILEPSY**

*Michelle Webster*

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Much of the existing sociological literature on the management of chronic childhood conditions within the family has given little attention to siblings. Where siblings have been considered the primary findings relate to the impact having a chronically ill child can have on siblings. However, there is little written regarding the role siblings play in the informal caregiving routines within the family. This paper will draw on research conducted for a doctoral thesis. The research took a multiple perspective approach; in-depth semi-structured interviews with parents from 24 families were conducted and auto-driven photo-elicitation interviews were carried out with the children with epilepsy and their siblings in 11 of those families. It will be argued that siblings play a significant role in the management of childhood epilepsy within the family as they act as both alert assistants and substitute parents. Furthermore, it will be demonstrated that family composition and the age of siblings can influence the roles they take on. It will be contended that both the alert assistant and substitute parent roles are primarily fulfilled when parents are not present. Moreover, it will be argued that performing these roles provides parents with comfort and allows the child with epilepsy freedom from parental supervision that they may not otherwise be afforded. It is intended that this research will contribute to the existing literature on the management of chronic conditions within the family and informal caregiving roles played by siblings.

**56975**

### **THE EXPERIENCE OF ADULT DAUGHTERS CARING FOR THEIR FRAIL OLDER PARENTS: A LONGITUDINAL PHENOMENOLOGICAL STUDY**

*Maja Lopez Hartman*

*S. Anthierens*

*E. Van Assche*

*J. Welvaert*

*V. Verhoeven*

*R. Remmen*

*J. Wens*

University of Antwerp, Belgium

**INTRODUCTION:** In the near future the ageing of the population will have a major impact on the demand for formal and informal long-term care services. Informal care is mainly provided by relatives, especially spouses and adult children. The objective of this study is describing how, why and with what consequences adult daughters experience caring for a frail older parent who lives at home.

**METHOD:** A qualitative longitudinal phenomenological study was performed in which 11 adult daughters of frail older persons have been followed during a one year period. At baseline, after 6 and 12 months we performed open ended interviews with the daughters. In between, we performed monthly telephone interviews. For the analysis of the data we used thematic analysis.

**RESULTS:** The daughter's most important role was being the 'advocate' of the parent. Caring is seen as a constant process of seeking a balance. Balancing between the carers' own household and that of the parent, between caring and having a normal parent-daughter relationship. For the women it goes without saying that they care for their parents, they feel it is their duty. The women that struggle the most are those who feel alone, who can not rely on a support network, resulting into difficulties in their life-care balance.

**CONCLUSIONS:** Understanding the lived experience of caring for an ageing parent from the carer's point of view can support other informal carers facing similar challenges and advice policymakers in making decisions concerning caregiver support services.

**51403**

### **STIGMA BY ASSOCIATION AMONG INFORMAL CARERS OF PEOPLE DIAGNOSED WITH BIPOLAR OR BORDERLINE PERSONALITY DISORDER**

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There has been very little empirical exploration and conceptual development of stigma by association in relation to mental illness since Goffman introduced the term courtesy stigma over 50 years ago. This paper addresses such lacunae, drawing on the findings of a PhD study which used a linked sample of people diagnosed with bipolar disorder or borderline personality disorder and their informal carers. These diagnoses are particularly under-researched in the mental illness stigma field. On the informal carer side of the study, presented here, 20 in-depth qualitative interviews were conducted and analysed thematically using abductive and retroductive inference, in line with the meta-theory of critical realism. Participants were recruited through charities and participant networking. Informal carers' experiences of stigma by association varied according to their primary role-relation to the diagnosed person. Experiences, for both informal carer groups, included undue pity/concern, blame, shame/embarrassment, self-stigma, marginalisation and 'secondary effects'. The concept of secondary effects describes the significant negative emotional, social and economic effects on informal carers consequent upon their loved ones' own stigmatisation experiences. Such experiences of stigma by association appeared to arise from a lack of understanding on the part of other actors occupying specific roles in social interaction. The results of this study were transmuted into Margaret Archer's basic morphogenetic model, which describes the temporal interplay of structure and agency, to show the process of stigma by association for the sample. This study shows that there is a need to tackle stigma by association, but this requires careful attention to nuances in experience between informal carers of people with different psychiatric diagnoses.

**57223**

### **CAREGIVING BY FAMILY MEMBERS**

*Monika Brzyska*

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**INTRODUCTION:** Increasing number of disabled individuals and people suffering from chronic conditions rise the demand for care, especially in home. Fulfilling a caring role is often associated with fatigue, distress and burden, as well as limitations in vocational and social life and can have negative impact on health and quality of life of carers. The aim of presented study was to assess the attitude to the caregiving and to identify main factors which influence the ability to perform the role of caregiver by family members.

**METHODS:** The cross-sectional study was carried out in the group of family carers living in Krakow, Poland. Respondents were contacted by several recruitment channels in order to represent a variety of caring situations. Data were collected using a structured questionnaire. Additionally, semi-structured in-depth interviews with selected family members were conducted.

**RESULTS:** The majority of the interviewed carers perceived the caring situation in family as unexpected and unplanned. Main reasons for undertaking the role of caregiver were: sense of duty, strong emotional bonds with care-recipient and lack of possibility to take care by other family members. The level of formal

support offered by relevant institutions is relatively low. Carers pointed out that they are often not adequately prepared to the role of caregiver and insufficiently supported by professionals and other family members.

**CONCLUSIONS:** Positive attitude to the caring role seems to be more important than other psychosocial resources which enable an individual to fulfil the role of caregiver satisfactory. However, ability to continue the caring role by family members is closely connected with received support.

## **Session 5C: Pre-organized session: Physical activity – social determinants and consequences II**

**Organizer and chair: Tomi Mäki-Opas, National Institute for Health and Welfare (THL), Helsinki, Finland**

**51578**

### **INCOME, PHYSICAL ACTIVITY AND THE COMPRESSION OF MORBIDITY. AN ANALYSIS FOR OLDER PEOPLE IN GERMANY**

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*Stefanie Sperlich*

*Siegfried Geyer*

Medical Sociology, Hannover Medical School, Germany

**INTRODUCTION:** The future development of morbidity among older people is of increasing importance for health care policies. The compression of morbidity by James F. Fries is often discussed as one of several directions morbidity will develop to. However, so far little is known about the role of socioeconomic factors in this context.

**METHODS:** The following questions were investigated: To what extent does the long-term development of subjective health among older people (aged 65 to 84 years) differ according to socioeconomic status? What is the meaning of physical activity in this context? Analyses were based on data from the German Socio-Economic Panel Study (1997 to 2010). By means of cohort comparisons the development of a (very) good subjective health was investigated for different income groups.

**RESULTS:** Respondents from later survey cohorts reported more often a (very) good subjective health than those from earlier. Health among older people with an above-average income improved much more than health among less affluent people. The multivariate analyses have shown that a higher socioeconomic status increased the chance of a (very) good subjective health. By entering physical activity in the regression model, there was no longer a significant impact of income on subjective health.

**CONCLUSIONS:** Socioeconomic differences could have an important meaning for the compression of morbidity. Results suggest that Fries' scenario could apply to people with a higher socioeconomic status more than to less affluent people. Against this background physical activity could play a central role by reducing social inequalities in health.

**56965**

### **RETIREMENT AND CHANGES IN LEISURE-TIME PHYSICAL ACTIVITY: A FOLLOW-UP STUDY**

*Anna-Leena Holstila*

*Jouni Lahti*

*Eero Lahelma*

*Ossi Rahkonen*

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**INTRODUCTION:** Physical activity is an important part of healthy ageing. Retirement from work increases free time thus potentially affecting leisure-time physical activity. However, ageing tends to decrease physical activity. The aim of this study was to examine how leisure-time physical activity changes after and during retirement.

**METHODS:** The baseline data were collected in 2000–2002 among 40–60-year-old employees of the City of Helsinki. First follow-up survey was conducted in 2007 (n=7332, response rate 83%) and second follow-up in 2012 (n=6814, response rate 79%). Respondents who were on disability retirement at the follow-up or



not in employment were excluded. This study included 5321 employees at baseline. Before the first follow-up, 911 participants retired due to old-age. Leisure-time physical activity was asked using similar questions in all three surveys.

**PRELIMINARY RESULTS:** Those retired before the first follow-up, increased their time used in leisure-time physical activity over 30 minutes per week, however, during retirement leisure-time physical activity decreased 30 minutes per week similarly among women and men. Those remained employed during the follow-ups, increased their physical activity (10 min/wk) during the first follow-up but decreased it during the second (20 min/wk). These changes were due to changes in moderate-intensity activity. Changes in vigorous activity were small.

**CONCLUSIONS:** Increases in physical activity due to retirement diminished when retirement continued. Physical activity should be promoted among retirees and those about to retire.

**56615**

### **ASSOCIATION OF PHYSICAL WORKLOAD AND LEISURE TIME PHYSICAL ACTIVITY WITH INCIDENT MOBILITY LIMITATION**

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*A. Møller*

*C. Nilsson*

*R. Lund*

*U. Christensen*

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Department of Public Health, University of Copenhagen, Denmark

**INTRODUCTION:** To examine individual as well as joint associations of physical workload and leisure time physical activity with incident mobility limitations in initially well-functioning middle-aged workers.

**METHODS:** This study is based on 6-year follow-up data of the Danish Longitudinal Study on Work, Unemployment and Health. Physical workload was reported at baseline and categorized as light, moderate or heavy. Baseline leisure time physical activity level was categorized as sedentary or active following the current recommendations on physical activity. Incidence of mobility limitations related to climbing stairs and running among initially well-functioning workers was assessed during follow-up (N=3202 for climbing stairs, N=2821 for running).

**RESULTS:** Higher workload increased whereas active leisure time decreased the risk of developing mobility limitations. The incidence of limitations increased progressively with higher workload regardless of level of leisure time physical activity, although the risks tended to be higher among those with sedentary leisure time compared to their active counterparts. All in all, the risk for onset of mobility limitations was highest among those with heavy workload combined with sedentary leisure time and lowest among those with light workload combined with active leisure time.

**CONCLUSIONS:** Although leisure time physical activity prevents development of mobility decline, high workload seems to accelerate the progression of mobility limitations among both those with active and sedentary leisure time. Therefore efforts should be made to recommend people to engage in physical activity regardless of their physical workload and to elucidate optimal interventions to prevent mobility decline among those with physically demanding work.

**59381**

### **MOBILITY ENHANCEMENT IN RESIDENTIAL AGED CARE – PROMOTING PHYSICAL ACTIVITY IN A HIGHLY VULNERABLE GROUP**

*Viktoria Quehenberger*

*Martin Cichocke*

*Karl Krajic*

Ludwig Boltzmann Institut for Health Promotion Research, Austria

**INTRODUCTION:** In residential aged care, there is a tradition to offer PA as mobility enhancement groups; mobility is a main element of health and health related quality of life within the aged. Users of residential aged care have a high prevalence of physical and cognitive functional impairments; yet even such a vulnerable group can benefit from exercise programmes. As the residence is often the centre of residents' lives, it seems crucial to promote PA in these settings and adapt PA programmes to needs and



resources of residents to facilitate participation. The study was part of a larger health promotion project ("Health has no age", 2011-2013) conducted in Vienna in three sites of Austria's largest residential care provider.

**METHODS:** The intervention was based on a scientific curriculum, conducted as a RCT (n=222) and evaluated in a formative and summative way. Data concerning implementation were gained through focus groups with various stakeholders, feedback sheets and meeting protocols.

**RESULTS:** Content and form of the programme seemed well adapted to residents' resources and needs. There are indications that individualization and personalized support were especially relevant for participation of functionally impaired individuals; variety of content of the programme and exercises' reference to everyday life (ADL) enhanced motivation of participants. Pro-active recruiting fostered to reach and motivate even previously inactive residents. The intervention significantly improved subjective health and occupational performance.

**CONCLUSIONS:** Experiences from this study show that it is possible to create a mobility enhancement intervention appropriate for resources of residents in aged care, which is attractive, feasible and effective.

## **Session 5D: WORK AND WELL-BEING III**

**Chair: Ossi Rahkonen, University of Helsinki, Finland**

**56924**

### **TRAJECTORIES OF ANTIDEPRESSANT MEDICATION BEFORE AND AFTER THE ONSET OF UNEMPLOYMENT**

*Taina Leinonen*

*Netta Mäki*

*Pekka Martikainen*

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**INTRODUCTION:** The role of health selection and causation is still unclear concerning the association between unemployment and ill health. This study examined trajectories of depressive morbidity before and after unemployment and re-employment.

**METHOD:** We used a register-based sample of the Finnish population to examine antidepressant medication over four years before and four years after the onset of unemployment (N=37,440) in 1996–2004 at the age of 30–60 compared to those with no unemployment (N=147,785). Those who stayed unemployed were examined separately from those who became re-employed. The analyses were based on linear regression models using generalised estimation equations (GEE).

**RESULTS:** Among those with no unemployment antidepressant medication increased slowly but steadily over the study years and it was at a lower overall level than among the unemployed groups. Among those who became unemployed without eventual re-employment antidepressant medication increased substantially until the first year of unemployment and afterwards more slowly. Among those who became re-employed the pre-unemployment increase in medication was more modest, and it was followed by a decrease after the first year of unemployment until the year of re-employment, after which the trajectory converged with that of the reference group.

**CONCLUSIONS:** Unemployment is preceded by worsening and re-employment by improving depressive morbidity. The study supports health selection more than a causal relationship between unemployment and mental health: depressive morbidity is more likely to lead to unemployment than vice versa, and more favourable developments in morbidity are more likely to be a cause than a consequence of re-employment.

**57249**

### **THE WELLBEING OF THE LONG-TERM UNEMPLOYED IN WESTERN UUSIMAA COUNTY**

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**INTRODUCTION:** In the globalized world the reality is fragmented; in every compass point there are those, who have and those, who have not. The mid-class working places are disappearing and

unemployment is increasing also among the previous mid-class as operative work is automated and qualification requirements become higher for the remaining positions. The structural changes will lead to increasing numbers of long-term unemployed.

**METHODS:** We have studied the wellbeing of the long-term unemployed in the Western Uusimaa County. First, regional statistics were analyzed in 2011. Second, a survey to the long-term unemployed was conducted in 2012 and third, the seamless multi-actor wellbeing path for the unemployed was constructed in a participatory workshop in 2013. Also digital story telling was used to interview individual unemployed people.

**RESULTS:** The Western Uusimaa county is less educated than other parts in southern Finland. Also, the unemployment rate is high. In the survey, the respondents had health problems: more than one third had overweight, almost one third had problems with sleep and only 1 % had been in the health control organized for the unemployed. In the open answers loneliness appeared as a serious problem.

**CONCLUSIONS:** The wellbeing of the long-term unemployed seems to be related to the level of financial compensation. Also, the unemployed people do not always have enough information about their rights. As a conclusion, the health and wellbeing services should be organized as seamless paths with tutors helping people to find available services and also to motivate to use them regularly.

**59376**

### **EMPLOYMENT, HEALTH, AND WELL-BEING. EVIDENCE FROM THE PALTAMO EMPLOYMENT MODEL EVALUATION**

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*Seppo Koskinen*

*Eila Linnanmäki*

*Tuija Martelin*

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**INTRODUCTION:** Europe is facing vast challenges caused by economic recession. A major concern is unemployment, which poses considerable risks for individuals (health and well-being) and threats for welfare states (social security systems). The National Institute for Health and Welfare (THL) coordinated the evaluation of a natural policy experiment which aimed at testing new ways of facing unemployment. In Paltamo, a municipality in Northern Finland exhibiting a high unemployment rate, a four-year full employment project was conducted from 2009 to 2013. It aimed to provide work for all jobseekers of the municipality.

**DATA AND METHODS:** In order to evaluate the impacts on health and well-being, data was collected for the research group (all jobseekers from Paltamo) and two control groups at three points of time by interviews, questionnaires, and health checks. It covered major aspects of physical health, functional capacity, health behaviour, mental well-being, dental health, quality of life, use of services, and social exclusion. The analyses comprised 900 persons aged 15-67, approximately 300 persons per group and were conducted in "Intention-to-Treat" panel regression models.

**RESULTS AND CONCLUSIONS:** The analyses showed a) substantial differences between employed and unemployed for most of the indicators, and b) that the majority of these differences persisted over the evaluation period. Nevertheless, the employment intervention had positive impacts on the jobseekers from Paltamo for some important aspects, such as e.g. back pain and use of painkillers, alcohol use disorders, eating habits, use of health care services, trust towards local policy-making, loneliness, and social participation.

57158

**THE EVOLUTION OF THE EMPLOYMENT QUALITY OF THE EUROPEAN YOUTH DURING THE PERIOD 2000-2010**

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*Laia Ollé*<sup>2</sup>

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**INTRODUCTION:** In recent years, the EU's labor market agenda had a strong focus on “flexicurity” as a strategy aimed at balancing labor market flexibility with social security for workers. However the flexibility-component has been more enhanced, than the security component. The evolution of the quality of employment in particular of young workers has been a neglected matter although raising important health concerns. Therefore this paper aims to analyze the evolution of health-related employment quality indicators among European young workers during the last decade.

**METHODS:** We have performed a descriptive trend analysis of the European Working Condition Surveys 2000/01, 2005 and 2010. All workers and employees aged from 20 to 24 years were included (N 10758).

**RESULTS:** The percentage of young workers with indefinite employment contracts decreased from 65% in 2000/01 to 52.0% in 2010. Also, major evolutions can be seen regarding quality of work indicators. An example is the strongly decreasing control over working time arrangements among young workers: from 2000/01 we saw an approximately 30% increase in working times being entirely controlled by the company (and not by the young workers themselves).

**CONCLUSIONS:** Our results show that employment quality of young workers tends to decrease during the last decade. This could have important consequences for health and well being and the sustainable integration in the labour market on the long run. Therefore we argue that research as well as policy makers should focus not only on youth unemployment but also on the employment quality of the European youth.

**Session 5E: Pre-organized session: National health transitions indicated by the change in main causes of hospitalization**

**Organizer and chair: Ari Väänänen, Finnish Institute of Occupational Health, Finland**

57127

**GENERAL TRANSITION IN HOSPITALIZATIONS IN FINLAND FROM THE MID-1970S TO 2010: SOCIETAL AND THEORETICAL BACKGROUND**

*Ari Väänänen*<sup>1</sup>

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During recent decades, most European nations have experienced considerable structural shifts in the labour market, educational attainment, and welfare, which have influenced the well-being and health of the population. However, the disease burden does not shift equally: some diseases may become more prevalent and some populations may be more vulnerable. It is surprising that there are no previous studies on national hospitalization trends that examine long-term proportional changes in the disease burden across main diagnostic groups in populations representing different occupational and educational statuses in society. This thematic session aims to discuss the health transition and changing burden of disease in the working-age population in Finland; a country that experienced dramatic societal change between the mid-1970s and

2010. It moved from secondary to tertiary production with considerable intensification of the production system. In the working-age population, the societal shift was reflected in changes in the occupational structure and job content, the overall growth of a highly-skilled workforce, the emergence of late modern work organizations based on the use of information technologies and mobile networks, and considerable changes in leisure time activities. This introductory presentation will briefly review the structural transition and present the different complementary sociological frameworks (e.g., tendencies towards democratization, emotionalization, psychologization). After this, more specific empirical papers will present our results, focusing on the transition in all-cause hospitalizations and hospitalizations for the main diagnostic categories from 1976 to 2010 in seven representative cohorts of the working-aged, representing different occupational statuses and the accompanying working conditions.

**50620**

### **NATIONAL TRENDS IN MAIN CAUSES OF HOSPITALISATION IN THE FINNISH WORKING-AGE POPULATION**

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*Lauri Kokkinen*<sup>3</sup>

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**INTRODUCTION:** The health transition theory argues that societal changes produce proportional changes in causes of disability and death. The aim of the study was to identify long-term changes in the main causes of hospitalisation among working-age men and women within a nation that has experienced significant societal change.

**METHOD:** National trends in all-cause hospitalisation and hospitalisations for the five main diagnostic categories were investigated in the data obtained from the Finnish Hospital Discharge Register. The seven-cohort sample covered the period from 1976 to 2010 and consisted of 3,769,356 randomly selected Finns, each cohort representing 25% sample of the working-age population.

**RESULTS:** Over the period of 35 years, the risk of hospitalisation for cardiovascular diseases and respiratory diseases decreased. Hospitalisation for musculoskeletal diseases increased whereas hospitalisations for mental and behavioural disorders slightly decreased. The risk of cancer hospitalisation decreased marginally in men but increased in women. Socio-economic differences in long-term changes in the main causes of hospitalisation will also be discussed in the presentation.

**CONCLUSIONS:** A considerable health transition related to hospitalisations and a shift in the utilisation of health care services of working-age men and women took place in Finland between 1976 and 2010.

**57133**

### **LONG-TERM TRENDS IN MAIN CAUSES OF HOSPITALIZATION AMONG SIX OCCUPATIONAL GROUPS IN FINLAND, 1976–2010**

*Pekka Varje*

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**INTRODUCTION:** The health transition theory predicts general shifts in morbidity structure within populations as societal conditions change. However, the possibility of a shared health transition among occupational groups has remained outside the scope of occupational health studies. The purpose of this study was to determine whether transitions in the hospitalisation structure of different occupational groups have followed similar trends.

**METHOD:** The incidence rates and proportional risks for all-cause hospitalisation and five main diagnostic categories among six occupational groups (nurses, teachers, metal workers, office clerks, salesclerks, and road transport workers) were examined between 1976 and 2010 in Finland, using register data on hospital

diagnoses. The study consisted of a five-year follow-up of 1,126,499 Finnish working-aged residents in seven consecutive cohorts.

**RESULTS:** Altogether 451,737 hospital admissions were investigated in 1976–2010. Despite significant differences in absolute incidence rates, the secular trends were notably similar for individual occupational groups. The risks for all-cause hospitalisation, mental disorders and respiratory illnesses remained relatively stable, whereas the risk for musculoskeletal disorders increased (between 31% and 90%) and the risk for cardiovascular diseases decreased (between 41% and 62%) in all occupational groups. The highest variation was found for cancer (HRs in 2006–2010 between 0.68 and 1.32).

**CONCLUSIONS:** A shared health transition seems to have occurred in the occupational groups studied, since the secular trends in hospitalisation structure were notably similar. Surprisingly, the health transition also sustained health disparities between the occupational groups.

**57207**

**DIFFERENCES IN HOSPITALIZATION RATIOS BETWEEN EMPLOYMENT INDUSTRIES, FINLAND 1976-8.302010**

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**INTRODUCTION:** Very little is known about the long-term relationship between the employment industry and employee morbidity. The aim of this register-based study was to investigate the differences in hospitalization ratios of the Finnish working-age population across different industries over a period of 35 years.

**METHOD:** Participants (n=3,769,355) were randomly selected from the Statistics Finland population database, from seven independent consecutive national cohorts, each representing a 25% sample of the working-age population. These data were linked with diagnosis-specific records on hospitalizations, drawn from the National Hospital Discharge Registry, using personal identification numbers.

**RESULTS:** Socio-demographics-adjusted models showed differences between proportional hospitalization ratios of employment industries in all-cause hospitalization, and these differences remained fairly stable during the total period of 35 years. In terms of cause-specific hospitalizations, there was more variation in secular trends and more fluctuation in the hazard ratios of different industries. The differences between the proportional hazard ratios of different industries that varied the most during the study period were those in hospitalization for mental disorders.

**CONCLUSIONS:** Proportional cause-specific hospitalization ratios have varied between employment industries. This fact might be related to industry-specific intensification of work. However, the differences in proportional all-cause hospitalization ratios have remained fairly stable, with the ranking between industries remaining almost the same over the past 35 years.



## **Session 5F: YOUNG PEOPLE II: Inequalities and life-course**

**Chair: Laura Kestilä, National Institute for Health and Welfare (THL), Finland**

**58722**

### **PARENTAL SOCIAL AND HEALTH-RELATED RISK FACTORS FOR POISONING AND INTENTIONAL INJURIES AMONG ADOLESCENT CHILDREN**

*Hanna Remes<sup>1</sup>*

*Pekka Martikainen<sup>1</sup>*

*Heta Moustgaard<sup>1</sup>*

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<sup>1</sup>Department of Social Research, University of Helsinki, Finland

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**INTRODUCTION:** During adolescence, poisonings and intentional injuries emerge as major causes of morbidity and mortality. Multiple parental factors are known to associate with children's health and injury risks but few studies have assessed parental social factors and parental health and health behaviours at the same time. We aim to find out to what extent the effects of childhood family structure and socioeconomic status on poisonings and intentional injuries among adolescents can be explained by mental disorders, substance abuse, and intentional injury morbidity among their parents.

**METHOD:** Based on longitudinal register data on a 20% representative sample of all families with children aged 0–14 years in 2000 in Finland, our dataset contains detailed information on family structure, parental socioeconomic status and health problems. We used Cox proportional hazards models to examine the associations between parental factors and hospital-treated poisonings and injuries due to intentional self-harm or interpersonal violence between ages 13–19 in 2001–2011.

**RESULTS:** Parental education, income, and occupational class were all associated with poisonings and intentional injuries. Excess risk also applied to children of non-intact and one-parent families. Adolescents, whose parents had received treatment for mental disorders, substance abuse, or intentional injuries, were likewise in higher risk of poisonings and injury morbidity. To a degree, different patterns were found between boys and girls, and according to maternal or paternal characteristics.

**CONCLUSIONS:** The higher risks of poisonings and intentional injuries among children from socially disadvantaged families are to an important extent mediated by parental mental health and substance use problems. Policies aimed at tackling injury morbidity among the young should focus on families with interrelated parental social and behavioural difficulties.

**53461**

### **PARENTAL EDUCATION, OWN EDUCATION AND SELF-RATED HEALTH IN GERMANY: EVIDENCE FROM THREE LIFE-COURSE MODELS**

*Benjamin Kuntz*

*Jens Hoebel*

*Thomas Lampert*

Department of Epidemiology and Health Monitoring, Robert Koch Institute, Berlin, Germany

**INTRODUCTION:** The life-course perspective in social epidemiology examines how socioeconomic factors across different life stages contribute to health inequalities in later life. Following three conceptual life-course models (critical period, accumulation, social mobility), we investigated associations between parental education, own education and self-rated health (SRH) in adulthood.

**METHOD:** Data were derived from five waves (2004–2012) of the biennially conducted cross-sectional German General Social Survey (GGSS). Analyses were restricted to respondents aged 25+ years ( $n = 14,540$ ). Parental and own education were measured using the CASMIN classification. SRH was assessed on a five-point scale from 'very good' to 'bad'. Logistic regression was used to calculate multiple adjusted odds ratios for less than good SRH.

**RESULTS:** Both parental and own education (low vs. high) were independently associated with less than good SRH, with stronger effects of own (men: OR 2.15, 1.84–2.51; women: OR 2.58, 2.15–3.09) compared to parental education (men: OR 1.30, 1.07–1.57; women: OR 1.29, 1.08–1.54). According to the accumulation model, less than good SRH was most likely among low-educated respondents whose parents were low-educated as well. Upward social mobility was linked to better SRH and downward mobility was linked to poorer SRH, supporting the social mobility model.



**CONCLUSIONS:** The findings suggest that parental education has mainly indirect effects on health in later life through intergenerational educational transmission. Improving educational prospects of children from lower-educated families might contribute to better health outcomes and could lead to reduced health inequalities. Longitudinal data is needed to disentangle social causation and social selection processes.

**57166**

**FAMILY ECONOMIC HARDSHIPS DURING RECESSION PREDICT CHILD'S ECONOMIC AND PSYCHIATRIC OUTCOMES IN YOUNG ADULTHOOD**

*Olli Kiviruusu*

*Päivi Santalahti*

*Tytti Solantaus*

National Institute for Health and Welfare (THL), Finland

**INTRODUCTION:** We studied whether family economic hardships experienced during a severe nationwide recession have an impact on child's economic attainment and mental health in early adulthood. **METHOD:** A sample of the 1981 birth cohort in Southern Finland was studied at ages 8 (before recession, in 1989) and 12 (during recession, in 1994) using questionnaires, and followed up to age 28 using register data (n=814). Measures of economic hardships during recession covered parental unemployment and job insecurity, family's reduced income and low income level. Register-based outcomes included child's use of income support and specialized psychiatric services in young adulthood (ages 18–28). Analyses were adjusted for child's pre-recession school performance and psychiatric symptoms, and other covariates (child gender, parental education, single-parent household).

**RESULTS:** In univariate analyses parental unemployment and low income level (but not income reduction) during recession predicted offspring use of income support and psychiatric services in young adulthood. Only current unemployment (in 1994) predicted the adverse outcomes, while earlier unemployment during recession did not. In multivariate models unemployment and low income had independent effects on both outcomes, also when adjusting for child's pre-recession psychosocial measures. When adjusting for all covariates only unemployment predicted offspring's young adulthood outcomes. Parental job insecurity (analysed separately) predicted child's later use of psychiatric services, but not use of income support. **CONCLUSIONS:** Parental unemployment and job insecurity in the aftermath of economic recession have negative effects on child's psychological wellbeing and economic attainment in young adulthood. Future studies should address the mechanisms underlying these connections.

**57164**

**REGISTER-BASED PROJECT ON HARMS TO CHILDREN CAUSED BY PARENTS' SUBSTANCE MISUSE**

*Marke Jääskeläinen<sup>1</sup>*

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**INTRODUCTION:** Abuse of alcohol and illegal drugs can cause harms to others than abuser him/herself. Parents' substance abuse can lead to inability to take care of children, to provide a safe environment, and to respond adequately to the child's physical and emotional needs. This project investigates health and welfare deficits related to the parents' substance abuse, and the impact of parents' substance abuse on their child's health and social welfare.

**METHOD:** A register-based longitudinal study on all Finnish children born in 1991, 1997 and 2002, and their biological parents. Data have been retrieved from the Finnish social and health care registers. **RESULTS:** Our results indicate that parental substance abuse causes various harms to children at every age. The under 7-years-old children of substance abusing mothers had a 30-fold risk of out-of-home placement. These children were also hospitalized more often before their 7th birthday because of injuries and infectious diseases. The adolescent (13-17 years old) children of substance abusing parents were at higher risk of having mental health disorders and misusing alcohol or other substances. The more socially disadvantaged the parents were, the higher the risks for negative outcomes were for children. Substance abusing parents are characterized by higher rates of mortality and psychological morbidity, having lower education level, single-parenting and poverty.

CONCLUSIONS: The parents with substance abuse problem and their children are in many ways vulnerable. There is an interplay between substance abuse and other health and social disadvantages which deepens the problems of substance abusing families.

## **PARALLEL SESSIONS VI**

### **FRIDAY 29 August at 15.00 - 16.20**

#### **Session 6A: Pre-organized session: Recession and health in Europe III: Social policy and health inequalities.**

**Organizer and chair: Tim Huijts, University of Oxford, UK**

**57324**

#### **“FUNDAMENTAL CAUSE” OF SOCIAL INEQUALITY IN HEALTH AND FINANCIAL CRISIS IN SPAIN**

*Ángel R. Zapata Moya<sup>1</sup>*

*Veerle Buffel<sup>2</sup>*

*Piet Bracke<sup>2</sup>*

*Clemente J. Navarro Yañez<sup>3</sup>*

<sup>1</sup> Public Health & Preventive Medicine Area. University of Pablo Olavide, Seville, Spain

<sup>2</sup> Ghent University, Belgium

<sup>3</sup> Pablo de Olavide University, Spain

INTRODUCTION: Inspired by a fundamental cause perspective (Link et al , 1998), we explore community level inequalities in highly and poorly preventable diseases in Spain. Some small area studies of the association between socioeconomic indices and preventable mortality found a gradient between most deprived and affluent areas. However, most small area studies on health inequality in Spain rely on aggregated information. The objective of the present study is to evaluate social inequalities in highly versus poorly preventable diseases. Moreover, we want to explore the impact of the present economic crisis on the extend of the health gradient in highly preventable diseases.

METHOD: We use the Spanish National Health Surveys (SNHS 2006 and 2011 waves) and the European Health Survey in Spain (EHS-S 2009), which provide cross-sectional representative information on non-institutionalized population ( n = 29478; n = 21007; and n= 22188 respectively). Logistic regressions were performed to calculate the adjusted Odds Ratio of experiencing a diagnosis of preventable diseases (myocardial infarction, heart diseases, diabetes, Chronic Anxiety or Depression), and less preventable diseases (malignant tumor) by education and social class. Possible confounding effects of age, sex and smoking were taken into account.

RESULTS: SES gradients in highly preventable morbidity were observed by education level and social class in all samples, while a SES gradient in self-declared diagnoses of cancer was absent. In addition, between 2006 and 2011, the gap among the less and the highest educated in chronic depression/anxiety, myocardial infarction, heart diseases and diabetes increased.

CONCLUSIONS: SES disparities in preventable diseases (cardiovascular diseases, diabetes and chronic anxiety/depression) increased drastically in Spain. During economic crisis, the budget cuts in public health care and in social policies could contribute to increase this gap in the near future.

**57167**

#### **THE EUROPEANIZATION OF LIVING CONDITIONS AND HEALTH**

*Sabine Israel*

University of Oldenburg, Germany

The purpose of the article is to set out in how far social processes promoted through the European integration have let to changes in the health status within the EU Member States over the last decade. On the one hand, the political and market integration has offered a new opportunity structure to European citizens allowing for increased mobility and market chances; on the other hand the EU's increased interconnectedness on all levels has also led to a progression of liberalization and re-commodification tendencies. Therefore multiple scenarios are be conceivable for the evolvement of health status and

inequalities across Europe. This article aims at filling the gap of European cross-country analysis by studying the macro-level factors on the health status and the incidence of bad health among different societal groups in Europe. This is done on the basis of cross-sectional analyses of EU-SILC data comparing health status and inequalities from 2005 to 2011. The study observes better living conditions and health for those Central and Eastern European Member States not hit by the crisis. While the health status is worsening in the Baltic Member States and within the austerity-shaken Mediterranean countries. Most importance for health status across Europe is exerted by those factors influencing decommodification, namely the unemployment rate and pension replacement rate. Also the structure of the labour market and their rigidities, which are expressed through the long-term unemployment rate and fixed-term jobs play a role. In sum, the “Europeanization” of the health dimension through European rules and structures is undeniable.

**57256**

# **THE GENDERED IMPACT OF THE CURRENT ECONOMIC CRISIS ON DEPRESSION IN EUROPE**

*Veerle Buffel*

*S. Van de Velde*

*Piet Bracke*

University of Ghent, Belgium

**INTRODUCTION:** The economic crisis has raised concerns about its impact on the mental health of men and women in Europe. Both sexes may be affected differently due to the gendered segregation of the labor market and the flexible reserve labor force. In addition, because masculine identity is intricately linked to having a job they may be more threatened and stigmatized by unemployment. Women, may be more likely to rely on alternative roles, which may act as substitutes to employment. The gendered impact of the economic crisis will possibly not be the same across the different countries as differences can be expected in women’s relative position in the labor market or welfare system which are linked to the varying degrees of attachment to employment and varying social norms and household arrangements.

**METHODS:** In the current study we use Wave 3 (2006) and 6 (2012) of the European Social Survey (N men=23253; N women=26984; 20 countries) to examine the impact of the economic crisis on depression in men and women. We differentiate between employment status, work hours and type of contract. The strength of the economic crisis was assessed via change in unemployment rate.

**RESULTS AND CONCLUSIONS:** We found that gender differences in depression are smaller in countries hit hardest by the crisis, where especially men of middle age are at risk, regardless of their current employment status. Being unemployed has a stronger negative effect on men, and this effect is the strongest for the middle aged men. In countries strongly affected by the present crisis, there is an increase in part-time work, and part-time working men are again found to be more depressive. This challenges the traditional view that women behave as employment buffers, which are pushed back when demand contracts.

## **Session 6B: Pre-organized session: Informal caregiving II**

**Organizer and chair: Ellen Verbakel, Department of Sociology, Radboud University Nijmegen, Netherlands**

**54086**

# **NETWORKS OF INFORMAL CARING: A MIXED METHODS APPROACH**

*Rutherford*

University of Stirling, UK

Care for older people is a complex phenomenon. Bringing together literatures on care from social gerontology and economics, we report the findings of a mixed-methods project exploring networks of informal caring. Using quantitative data from the British Household Panel Survey together with qualitative interviews with older people and informal carers we describe different care networks, and the factors and decision-making processes that have contributed to the formation of the networks. Our conceptualisation of care networks advances on previous research particularly by including formal care, and exploring

complementarities and substitutions in a set of real examples. Caring activity has been addressed differently by several disciplines. These literatures are not well integrated, and each neglects some important aspects of care. Studying care as a network allows both the individual and social characteristics of caring relationships to be studied, bringing together literatures in economics and social gerontology. Both quantitative and qualitative methodologies, in a mixed methods approach, are required to fully understand the phenomenon of informal care and its intersections with formal care. The quantitative analysis allows us to describe the complexity of care networks, and to provide a picture of the relative frequencies of network types in the UK, grounded in large scale survey data and moving beyond Wenger's (1991) classification of types of network according to their vulnerability. The qualitative analysis allows us to focus on the factors affecting decision making, and to highlight the importance of timing and path dependency that led to the formation of care networks as we observed them. This helps understanding of how care networks change over time, a key concern of ours and other studies, but a little understood area.

**56175**

### **WHY CAREGIVERS INSTITUTIONALIZE FAMILY MEMBERS; EXAMINING GENDER AND RELATIONSHIP INTERSECTIONS**

*Neena Chappell*

University of Victoria, Canada

We know much about caregivers' decisions to institutionalize older family members with dementia in terms of problem behaviours and the demands of personal care. In addition, non-spousal caregivers are more likely to place family members than are spouses but little is known about the gendered natures of these differences. We also know that women caregivers are more involved in emotional and personal task caregiving, but we do not know how these two facets interact within the context of placement. Furthermore, little of this research is prospective and longitudinal. This paper draws on data from a larger province-wide study of caregivers to those with dementia living in B.C., Canada. Spousal and Adult-child caregivers were interviewed face-to-face for, on average, 1.5 hours shortly after the diagnosis of dementia and again one year later when 168 were in nursing homes. A random sample of 1/3rd of those remaining in the community was drawn for comparative purposes (N = 339 for these analyses). Multivariate logistic regressions identified which factors at T1 lead caregivers to institutionalization by T2. The results confirm past research indicating that adult-child caregivers are more likely to institutionalize than spouses. However, for daughters, the lack of help from other family members or friends, is a critical factor not relevant for sons, wives or husbands. The findings are discussed in terms of the different life stages of and role demands on adult-child caregivers compared with spouses, of the differential caring roles of women and men and the subsequent need for differential support.

**57233**

### **UNDERSTANDING DUTCH INFORMAL CAREGIVER'S WELL-BEING: ADJUSTMENTS OF THE STRESS/APPRaisal MODEL**

*Ellen Verbakel<sup>1</sup>*

*Silke Metzelthin<sup>2</sup>*

*Ruud Kempen<sup>2</sup>*

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<sup>2</sup>Department of Health Services Research, Maastricht University, The Netherlands

Ageing society, rising health care costs, and government policy directed towards own responsibility of citizens will result in an increasing role of informal care. Research has shown that informal caregiving produces burden and lower levels of well-being among caregivers. It is necessary to understand how lower levels of well-being among caregivers emerge in order to develop interventions to support informal caregivers and keep a sustainable pool of informal caregivers in the future. This study answers the questions: (1) what determinants affect caregiver's well-being, and (2) under which conditions are determinants more or less strongly related to caregiver's well-being. This study uses an adjusted version of the stress/appraisal model (Yates, 1999). Four factors that form consecutive stages in the stress model are assumed to affect well-being: primary stressors indicative of the care recipient's health status (1) will affect caregiver's primary appraisal that mirrors the caregiver's evaluation how much time will be spent on care (2); this caregiving intensity will positively affect caregivers' secondary appraisal, i.e. the perceived burden (3), which is expected to reduce caregiver's well-being. The relationship between each of these stages is

expected to be moderated by formal care services, social support, characteristics of the caregiver-recipient relationship, and the emotional state of the care recipient. The theoretical model will be tested with the TOPICS-MDS dataset, which includes over 4,000 dyads of care recipients and their caregivers in the Netherlands. They completed questionnaires covering information on all stages of the stress/appraisal model. Data become available for analysis in March 2014. Yates, M. E., Tennstedt, S. and Chang, B-H. (1999) 'Contributors to and Mediators of Psychological Well-Being for Informal Caregivers.' *Journal of Gerontology: Psychological Sciences* 54B (1): 12-22.

## **Session 6C: HEALTH AND AGEING I**

**Chair: Eero Lahelma, University of Helsinki, Finland**

**62562**

### **SOCIAL DETERMINANTS, LIFE COURSE AND HEALTH SERVICE USE IN A SITUATION OF AGEING DEPENDENCY**

*Damien Cassan*

CLERSE -Lille University, France

Ageing dependency is an increasing global challenge for society with economical, social and health issues. French national survey show that the North department is behind national average in terms of health inequalities, life expectancy, and dependency rates. Therefore, the Council of the North Department is sponsoring social sciences research on the development of neurodegenerative disorders and dependency in the ageing population. Our research aims at selecting 30 elderly people from different social classes and investigating their life course especially in the process of dependency as well as their health care experience. Moreover, specific geographic sectors have been selected to provide monograph studies. Research will also evaluate whether a recently implemented public health and social care services meet the needs of the dependent population and contribute to the reduction of health inequalities. Ongoing qualitative fieldwork consists on joining professionals visiting elderly dependent people, and interviewing altogether professionals, elderly people and their close ones to get a clearer evaluation of the situation. The preliminary results show that elderly people, regardless of social class, have a general tendency to deny the neurodegenerative disorders. Striking differences appears when it comes to the use of health care public services. Elderly people from the higher social classes hire private home care workers through their personal networking since they do not trust or at least do not feel comfortable with strangers. Individuals from ethnic minorities also tend to use public service care workers at a minimum because of stronger bonds within families and a tendency to deal internally with such matters.

**57151**

### **OLDER PEOPLE'S VULNERABILITY TO AND RISK OF FOODBORNE ILLNESS IN THE HOME SETTING**

*Wendy J. Wills*

*Angela M. Dickinson*

University of Hertfordshire, UK

**INTRODUCTION:** Recent increases in cases of Listeriosis in older people have focused attention on food preparation, storage and consumption, including in the home setting. Previous studies have concentrated on examining knowledge, attitudes and reported behaviour therefore the aim of Kitchen Life was to observe what 'actually happens' in domestic kitchens to assess whether and how this has the potential to influence food safety. We drew on current theories of practice to see individuals as one piece of an overall jigsaw puzzle that also examines the household setting, technologies, material objects and pets within the home along with the shared values and meanings that practices become imbued with.

**METHODS:** Using a qualitative approach, methods include a kitchen tour, photography/photo elicitation, video/direct observation, informal interviews and diary methods. Ten households with older people (60-79 years and 80+) were recruited across the UK along with ten households with people aged <60 years.

**RESULTS:** We suggest vulnerability is influenced by changes in sensory and cognitive perception and physical capacity whereas older people's risk status is affected by their 'food values' as well as shifts in practices and circumstances. Trust in the food supply chain, inconsistent use of food-labelling and attitudes to food waste influenced potential risk of foodborne illness. Bereavement, living alone and receiving help



with domestic tasks influenced kitchen practice and interacted in different ways with changes in vulnerability status.

**CONCLUSIONS:** The study provides important insights for considering the complex pathways between vulnerability and risk and the ways such pathways operate for different groups of older people.

**54001**

### **AGEISM IN AN AGEING SOCIETY: PERSPECTIVES ON YOUNG PEOPLE**

*Penny Curtis*

*A. James*

*J. Britton*

*K. Ellis*

Centre for the Study of Childhood and Youth, University of Sheffield, UK

**INTRODUCTION:** The concept of ageism has been widely invoked to explore and explain the transformation of ageing from a natural process into a social problem that is associated with detrimental consequences for individuals. However, although the possibility that ageism can ‘go both ways’ is noted in the literature, ‘ageism’ is seen, overwhelmingly, to only influence the lives and experiences of older people.

This paper considers how temporal constructions of age are negotiated in and through the narratives of older people and asks whether such constructions contribute to the experience of ageism by young people.

**METHODS:** Small group or individual interviews were conducted with 20 young people aged between 12–17 years in schools and community settings. Seventeen older people aged, 65–90 years of age also participated in focus group discussions in one industrial city in the north of England.

**RESULTS:** Older-people’s narratives around youth draw upon categorisation, identification and comparison to construct temporally specific, generational understandings of young people and their lives. By drawing upon stereotypical notions of the lifestyles, cultural practices, manners and discipline of contemporary young people, older people convey generational values that inform ageist, deficit notions of contemporary youth and which associate young people with risk and threat.

**CONCLUSIONS:** While others have drawn attention to ‘childism’ or ‘youthism’ to highlight prejudicial attitudes to young people, this paper demonstrates that the notion of ageism has resonance for young as well as older people. The paper concludes by considering the potential importance of intergenerational knowing to ameliorate prejudicial generational attitudes.

**59371**

### **PREDICTING MOBILITY LIMITATIONS USING A REPEATED MEASUREMENTS POPULATION SURVEY DATA**

*Tommi Härkänen*

*Päivi Sainio*

*Seppo Koskinen*

National Institute for Health and Welfare (THL), Finland

**INTRODUCTION:** The number of older people is expected to double within next decades in Finland and in other Western societies. Information on the future development of functioning of the older population is needed for planning health and welfare policy. This study is based on the statistical multiple imputation techniques to predict both the number of persons having mobility limitations in the future and the population size.

**METHODS:** The nationally representative Health 2000 survey (BRIF8901) conducted in 2000–01 and its follow-up 11 years later (the Health 2011 survey) contain information on individual changes in walking disability and its modifiable determinants (high BMI, smoking and low level of physical activity) among adult Finns. These data were used to produce predictions of mobility limitations in 2022, 2033, and 2044. Results based on different scenarios assuming prevalence reductions of the risk factors are presented to assess their importance. Prediction intervals are also provided to assess the accuracy of the predictions.

**RESULTS:** The number of persons aged 52 years or older with severe walking limitation will nearly double between 2011 and 2044, assuming that the prevalence of limitations remains at the level observed in 2011. The scenario, in which the prevalence of obesity would halve, will produce substantial reductions in the number of disabled persons.

**CONCLUSIONS:** The predicted increase in the number of disabled persons accentuates the need to reduce prevalence of modifiable determinants of disability, obesity in particular, and to assure sufficient social



services and care for the disabled persons. The prediction model introduced in this study has great potential to be further developed and utilized in various other health problems.

## **Session 6D: HEALTH AND IMMIGRANTS I**

**Chair: Annika Lillrank, University of Helsinki, Finland**

**57283**

### **THE EAST IN THE NORTH – AN ECOLOGY OF HEALTH IN A NORTHERN ENGLISH CITY**

*Neil Small*

University of Bradford, UK

Cities across the world exhibit pronounced inequalities. Many of these inequalities are enhanced by minority ethnic status and migration history. Sometimes different dimensions of inequality act together, characteristically wealth can be correlated with health. Sometimes, even within groups with the same level of wealth, there are considerable differences. For example rates of diabetes in people of Pakistani origin in the UK are considerably higher than rates for people of white British origin even when matched by socioeconomic position. This paper reports findings from Born in Bradford, an ongoing birth cohort study investigating 13818 babies born in this northern English city between 2007 and 2011. Half of families recruited to the study are in the poorest fifth of deprivation in England and Wales and 45% are of Pakistani origin (of these half of mothers were born in Pakistan). Rates of infant mortality are strongly associated with socioeconomic position but, within the same deprivation categories, rates are highest in babies of Pakistani origin. These babies have lower birth weights (a predictor of childhood morbidity) but are relatively fatter than white British babies (a predictor of later childhood obesity and adverse cardiometabolic outcomes including diabetes.) Health ecologies in cities across the world are hybrid in nature, they contain different but coexisting determinates of inequalities in health. This presents a methodological challenge in understanding the relative significance of different causal mechanisms and a challenge to the design and delivery of health care interventions.

**57049**

### **CLUSTERING OF NEGATIVE LIFE EVENTS AND CARDIOVASCULAR DISEASE RISK AMONG IMMIGRANTS IN FINLAND**

*Natalia Skogberg*

*Päivikki Koponen*

*Tiina Laatikainen*

National Institute for Health and Welfare (THL), Finland

**INTRODUCTION:** Cardiovascular diseases (CVD) are the leading cause of mortality in the world. In addition to age, gender, marital status and SES, immigrant health is influenced by the level of integration and racial discrimination.

**METHODS:** A random sample of 3000 immigrants of Russian, Kurdish and Somali origin, aged 18-64 were invited to participate in the first large-scale survey on Migrant health and wellbeing in Finland. Analysis includes negative life events prior to migration (traumatic events), migration process (residence permit) and post-migration experiences (violence, discrimination, psychological distress, low social support, low integration, poor health, discordance in job demands, financial difficulty). The association between negative life events score and CVD risk (dyslipidemia, hyperglycemia, hypertension, abdominal obesity, overweight, smoking) are examined with logistic regression model, adjusting for age and SES and stratifying by ethnicity and gender.

**RESULTS:** According to preliminary results, there are statistically significant differences in CVD risk profiles of the three immigrant groups. The least favourable profiles were identified for Kurdish immigrants. Of Kurdish men, 27% had elevated blood glucose, 31% had low HDL cholesterol, 49% were overweight and 15% were obese. Of Kurdish women, 38% had low HDL cholesterol, 43% were overweight, 23% were obese, and 30% had abdominal obesity. The Kurdish men and women also had most negative life events.

**CONCLUSIONS:** There are significant differences between the immigrant groups both in CVD risk and negative life events. Also negative life events vary among immigrant groups and seen to influence CVD risk. The related mechanisms need further exploring.

57119

**IDENTITY CONSTRUCTIONS OF MUSLIMS WITH MENTAL HEALTH PROBLEMS: A THEORETICAL INVESTIGATION**

*Elise Rondelez*

*G. Roets*

*Piet Bracke*

*S. Bracke*

University of Ghent, Belgium

**INTRODUCTION:** An underrepresentation of Muslims with a migrant background is observed both in mental healthcare settings, as well as in mental health care policy development. Also at the level of theory development attention to this subgroup of the population is limited. This paper starts from the hypothesis that at least part of this underrepresentation and lack of attention is due to the fact that many theoretical approaches do not take fully into account the specificities of this subpopulation, and asks what theoretical development might be needed to address this lacuna in the scholarship.

**METHODS:** A critical theory inspired literature review of a selection based on the keywords 'Islam' and 'mental illness', 'Muslim migrants' and 'mental health' etc. was performed. The critical theory approach focuses on question of the cultural specificity of illnesses and disorders, as well as the constitutive role of religion, ethnicity and gender in the construction of the (European) Cartesian subject.

**RESULTS:** Three tendencies that complicate research of mental health and Muslims with a migration background are identified: (a) a lack of sociological research, (b) the persistence of mechanisms of powering and othering, and (c) a persistence lack of attention of agency through the selected literature.

**CONCLUSIONS:** There are still compelling questions and theoretical issues to address in research to mental health of Muslims of migration background that could contribute to the tackling down of their social and scientific underrepresentation as well as to our analytical grip on this subpopulation.

**Session 6E: HEALTH PROMOTION AND SERVICES I**

**Chair:** Karl Krajic, Ludwig Boltzmann Institut Health Promotion Research, Vienna, Austria

59223

**TRANSFORMING RESIDENTIAL AGED CARE INTO A HEALTH PROMOTING SETTING? RESULTS FROM AN AUSTRIAN PILOT PROJECT**

*Karl Krajic*

*Viktoria Quehenberger*

*Martin Cichocke*

Health Promotion Research, Ludwig Boltzmann Institute, Austria

**INTRODUCTION:** So far, the settings approach for health promotion, addressing determinants of health in local communities and organizations, has not been systematically applied to aged care. Yet aged care residencies as people processing organizations bear a good potential to promote health. The paper provides insights into health promotion in aged care based on a health promoting settings-project (2011-2013) in three sites (900 residents, 300 staff) in Vienna.

**METHODS:** Starting with a systematic needs assessment (quantitative and qualitative), overall health promotion strategies and measures were developed. The project was evaluated in a formative and summative way, using qualitative and quantitative methods. A mobility enhancement intervention for residents was carried out as RCT.

**RESULTS:** Overall, the project was considered successful by internal and external stakeholders. The mobility intervention for residents proved to be feasible and effective and was rolled out to further units of the provider. Measures concerning staff health, like "health circles" (moderated group discussions) and "ergonomic guides" (new work roles for selected staff) brought up mixed results. At management level, a health promotion policy was formally adopted and central structures were established. The impact of these strategic and structural decisions on everyday processes and on organizational culture at local level is not yet clear, with different internal and external factors impacting.

**CONCLUSIONS:** The project provides evidence that connectivity for health promotion to aged care can be established; strategies, measures and instruments can be adapted and implemented. Project experiences help to learn about factors supporting or inhibiting implementation.

**59403**

**COMMUNITY DEVELOPMENT AND EMPOWERMENT FOR HEALTH: PUBLIC HEALTH ACTION AND ITS EVALUATION**

*Waldemar Suess*

Universitätsklinikum Hamburg-Eppendorf (UKE), Germany

**AIM:** Development and evaluation of an integrated action plan on health promotion in a disadvantaged district by public private partnership of the local health authority and a research project of the University Medical Center of Hamburg.

**SUBJECT AND METHODS:** The research project had two major goals that refer to the Public Health Action Cycle: > Development of small-scale health reports in view of benefits for process and outcome control, as well as situation analysis. > Development and testing of an evaluation method for setting-related prevention/health promotion ("capacity building"). The "science practice project" is based on a mix of quantitative and qualitative methods (secondary statistical analyses, expert interviews, interviews with residents, etc.).

**RESULTS:** An "integrated concept for 7 fields of action (including 2 cross-sectional areas)" was developed as inter-sectorial plan for dynamic management of local actions. By implementing the strategic concept, aims of the integrated fields of action were to be met as well as new aims, which had emerged during the course of the programme. Core quality criteria and requirements for a sustainable integrated action will be presented.

**CONCLUSIONS:** Successful courses of action to improve quality of life in disadvantaged districts ask for integrated action plans due to complex problems on the one hand, and manifold relations and constellations between involved actors on the other. **Keywords:** Public health services. Local prevention programme. Community development. Disadvantaged people.

**57141**

**THE PERSONAL WELLBEING PATHWAY MODEL FOR HOLISTIC, CITIZEN CENTRIC AND HEALTH PROMOTIVE CARE**

*Hanna Tuohimaa*

Laurea University of Applied Sciences, Finland

**INTRODUCTION:** Ways to motivate healthy lifestyles are appreciated as the population ages and the prevalence of chronic diseases increases. This requires responding to the needs and preferences of the citizens in service production proactively and in a health promotive manner and highlighting the active role of the citizen in making decisions concerning his/her treatment and life in general. Also the aspects of care that support psychological wellbeing and social inclusion in society must be acknowledged.

**METHOD:** 64 heart patients were interviewed about their experiences on their care pathway. Specific problems in the care pathways were identified. Also workshops for local health service providers were organized. This empirical data was combined with theoretical literature and prior research to define a health promotive wellbeing pathway with the goal being to motivate healthy living and to empower the individual in his/her life.

**RESULTS:** In the personal wellbeing pathway model, the elements of participation, support (including social support as well as tangible support), information, seamlessness of care and attitudes and knowhow were identified as the main aspects of the ideal care process in addition to the medical care necessary.

**CONCLUSIONS:** The model highlights the elements needed in the care process from the point of view of the citizen to enhance wellbeing and pursue health related goals. With services attuned to holistically supporting wellbeing in collaboration with public, private and third sector service providers, the society can better respond to the health needs of the residents from different backgrounds and with different needs and resources.

59354

## **ONCOLOGIC DISEASES: TWO SIDES OF THE SAME COIN**

*Paula Silva*

Institute of Molecular Pathology and Immunology, University of Porto (IPATIMUP), Portugal

The health field has been witnessing a redefinition of the disciplines that structure it, which results in a rearrangement of the knowledge and skills of their agents. This evidence is expressed in variable degrees and points to a more diligent and informed attitude of patients in the management of their illnesses. However, this tendency does not display enough strength in order to interfere with the internal dynamics of health/disease domain. This paper reports on a multidisciplinary project entitled “Knowing disease: patients first”, developed in the Institute of Molecular Pathology and Immunology at the University of Porto (IPATIMUP, Portugal) and funded by Calouste Gulbenkian Foundation. Usually, the biomedical perspective strictly aims to reset the state of health but it does not incorporate the multiple dimensions that the illness experience encloses throughout its extent. This study explores the multidimensionality in this issue through the discourse analysis of oncological patients, using a strategy of action inquiry framed in a contemporary approach of Grounded Theory methodology. The population is composed of 100 individuals of both genres who accessed specialty appointments of two public hospitals in Porto. Semi-structured interviews have been conducted with patients with breast, lung, colon, esophagus and prostate cancers, being the qualitative analysis performed with NVivo 10 software. The script is based on McGill Illness Narrative Interview (MINI), designed to stimulate illness narratives in health research. Socio-biographical profile of the population was also collected in order to contextualize the information derived from patient narratives in their social conditions, symbolic and material resources and respective paths of life. Grounded theory methodology assisted us to develop a model concerning the personal and social construction of oncologic disease, and produces findings with potential usefulness to patients, professionals and researchers.

## **Session 6F: MORTALITY I**

**Chair:** Hanna Remes, University of Helsinki, Finland

54407

## **THE SECOND MORTALITY TRANSITION: A NEW LOOK AT LONG TERM TRENDS IN MORTALITY DECLINE**

*Jon Anson*

Ben-Gurion University of the Negev, Israel

Demographic transitions occur in stages. We argue that there have been two mortality transitions, and that the European and European-overseas countries for which reliable long-term mortality data exist completed the first stage of the mortality transition around the middle of the twentieth century. In the first stage, or First Mortality Transition (FMT), from the nineteenth to the middle of the twentieth century, mortality decline occurred mainly at younger ages, survivorship to age 50 increased, and there was a secular growth in the rate of ageing (the rate of mortality increase above age 50) over and above that due to the decline in the mortality rate at age 50. By the 1950s, however, this transition was more or less complete, and the underlying level of survivorship to age 50 began to stabilise. In the Second Mortality Transition (SMT) the main weight of mortality decline thus shifted to older ages, above age 50, and the secular trend in the rate of ageing now changed from positive to negative, offsetting the continuing decline in the rate of mortality at age 50. There are important differences between countries in the patterning of these changes, and in particular, the patterns differ for males and for females. However, the changes over time have been identical for both sexes. Analysis of country-level variations, by sex, in terms of wealth and inequality, will enable us to understand further the reasons for this shift from the First to the Second Mortality Transition and the differences in the pace at which it has occurred.

57217

# **WHY AND HOW HAVE INEQUALITIES IN MORTALITY EMERGED? CAUSE-SPECIFIC MORTALITY IN A MIDDLE-INCOME EUROPEAN COUNTRY**

*Katalin Kovacs*

Demographic Research Institute

In Central Eastern Europe mortality inequalities by education have been proven to be especially large. Long term cause-specific mortality series can help understand the origin of inequalities, but these studies face several challenges such as changes in coding mortality. We investigated cause-specific mortality trends and mortality inequalities by education in Hungary between 1971 and 2008 with special attention to these challenges. Annual sex, age and cause-specific mortality data were retrieved from the mortality register of the Hungarian Central Statistical Office. Corresponding population data were taken from censuses or they were estimated for the mid-census years. Standardised time series were adjusted for the three changes in coding. Education-specific time series were broken down to subsequent periods of approximately linear (growing, stagnating, declining) phases using join-point regression. The patterns of mortality of the less and the more educated were compared for 57 causes of death. Inequalities in overall mortality started to increase from about 1980, coinciding with rising mortality inequalities from several cardiovascular causes, nutrition-related cancers and nutrition-related diseases of the digestive system, notably diabetes. Mortality inequalities in causes associated with other risk factors emerged later and during wider time periods so their impact is much less obvious. The emergence of inequalities in mortality run in parallel with the transformation of the Hungarian food provision system but not in parallel with changes in income inequalities during the 1980s. From 1990 the influence of growing income inequalities on mortality inequalities is obvious but still partly channelled by inequalities in the quality of nutrition.

59129

# **SOCIOECONOMIC DIFFERENCES IN CAUSE-SPECIFIC MORTALITY AFTER DISABILITY RETIREMENT DUE TO DIFFERENT DIAGNOSES**

*Anu Polvinen<sup>1</sup>*

*M. Laaksonen<sup>1</sup>*

*R. Gould<sup>1</sup>*

*Eero Lahelma<sup>2</sup>*

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**INTRODUCTION:** Socioeconomic inequalities in disability retirement and mortality are large. In this study the major interest is to examine socioeconomic differences in cause specific mortality after disability retirement due to different diseases. The second aim is to compare socioeconomic differences in mortality after disability retirement to socioeconomic differences in mortality in the general population.

**METHODS:** The data were administrative register data from Statistics Finland. Data are 11 % sample of Finnish population between years 1987-2007. Data include 80 % oversample of deceased during follow-up period 1988-2007. The study consists of those who were at baseline 30-64 years old or turned 30 years during follow-up. We used Cox regression analysis to study socioeconomic differences in mortality after disability retirement.

**RESULTS:** Mortality was high after disability retirement due to neoplasms, mental disorders and cardiovascular diseases. However, socioeconomic differences in mortality after disability retirement were small. Manual workers had slightly higher risk of mortality after disability retirement due to mental disorders (HR 1.59, 95% CI 1.40-1.80 for men; HR 1.29, 95% CI 1.00-1.47 for women) or cardiovascular diseases (HR 1.23, 95% CI 1.09-1.39 for men; HR 1.33, 95% CI 0.97-1.84 for women) than upper non-manual employees. Socioeconomic differences in mortality after disability retirement were smaller as compared to those with no disability retirement.

**CONCLUSIONS:** Excess mortality after disability retirement due to mental disorders and cardiovascular diseases among lower socioeconomic groups was evident. More attention should be focused on inequalities in mortality after disability retirement due to these diseases.



49891

**SOCIO-DEMOGRAPHIC DETERMINANTS AND PLACE OF DEATH: A RETROSPECTIVE ANALYSIS USING ADMINISTRATIVE DATA FROM SWITZERLAND**

*Damian Hedinger*

University of Zurich, Switzerland

**INTRODUCTION:** In spite of an overwhelming individual preference for dying at home, in developed countries generally about 7 out of 10 deaths occur in an acute care hospital or a long-term care facility. This study examines the influence of socio-demographic factors on different places of deaths.

**DATA AND METHODS:** We used individual data from hospitals and nursing homes that were linked with census and mortality records. So we can differ between those who died in a hospital, in a nursing home or at home. In gender-specific models we analyse individuals, born before 1942 (generally older than 65 years) and died in 2007 and 2008. Descriptive analysis and multivariate logistic regression models are used.

**RESULTS:** Our analysis showed that in both gender place of death is significantly associated with age, region of residence, educational level, marital status and household situation. Old women have a greater probability of dying in a nursing home, whereas younger men rather die in a hospital or at home. Being single, divorced or widowed increases the risk of dying in a nursing home, especially for women. Furthermore, people with a lower educational level die more often in a nursing home than those with a higher education.

**CONCLUSIONS:** If we analyse place of death, social inequalities matter - also after control for other important determinants such as age or diseases. Are people with lower education really more in need of care that they die more often in a nursing home? Or are there other reasons, e.g. that it is cheaper to place them in nursing homes than hospitals? Previous socio-epidemiological research supports the first explanation, but our analyses show that alternative reasons shouldn't be underestimated. Generally, more solid empirical research is needed.

## **PARALLEL SESSIONS VII**

**FRIDAY 29 August at 16.30 - 18.00**

### **Session 7A: Pre-organized session: Comparative research and health inequalities**

**Organizers and chairs: Piet Bracke and Sarah van de Velde, University of Ghent, Belgium**

57268

**REDUCING THE DOUBLE BURDEN IN DUAL EARNER FAMILIES BY DEGENDERIZING CHILD CARE RESPONSIBILITIES IN EUROPE**

*Sarah Van de Velde*

University of Ghent, Belgium

**INTRODUCTION:** Women suffer about twice as often from depression as men. Researchers often point to the increase in women's employment, not matched by an increase in men's care work and housework, causing women to become burdened due to work/family conflict. In the current paper, we focus on the effect of state support for child care, and parental leaves as a means to study the degree to which social policies degenderize child care responsibilities.

**METHODS:** In line with Saxonberg (2013) we differentiate between degenderizing family policies (long parental leaves open to both parents, high replacement rates, widely available public childcare), implicitly genderizing policies (means-tested or short parental leaves restricted to mothers, private child care), and explicitly genderizing (promotion of male breadwinner system). We focus on dual earner families because they face special challenges as they try to balance work and family responsibilities. Using wave 6 (2012) of the European Social Survey (N dual earners = 11603), we examine the effect of degenderizing policies on the level of depression in men and women in dual earner families.

**RESULTS AND CONCLUSIONS:** Preliminary results showed that degenderizing family policies are most effective at tackling depression in dual earner families, while implicitly genderizing social policies are least effective. This is especially reflected in lower income women who have fewer options of affordable child care. Thus, while these market-liberal types of policies do not openly promote separate gender roles, the



lack of affordable child care and short parental leaves privileged for mothers only, are especially detrimental for gender differences in depression.

**54113**

**DO FINANCIAL STRAIN AND LABOUR FORCE STATUS EXPLAIN NORDIC COUNTRIES' RELATIVELY WIDE HEALTH INEQUALITIES?**

*Richard Shaw*

MRC/CSO Social and Public Health Sciences Unit, University of Glasgow, UK

**INTRODUCTION:** Nordic countries, despite egalitarian social policies, do not have the smallest health inequalities. A possible explanation for this is that key drivers of class differences in health, such as financial strain and labour force status, remain socially patterned in Nordic countries.

**METHODS:** Data from 5 rounds for twenty countries in the European Social Survey for men (n= 48,249) and women (n=52,654) aged between 25 and 59. By country, using linear regression models, we investigated the degree to which class inequalities in self-rated health were explained by financial strain and labour force status.

**RESULTS:** We found social class gradients in financial strain and labour force status for all countries, but countries varied in overall levels of financial strain and employment. Relatively, Nordic countries had large inequalities in self-rated health before adjustment. Adjusting for labour force status and financial strain attenuated some of these differences for example for working class men in Finland the regression coefficients changed from 0.29 (95% CI 0.23 to 0.036) to 0.17 (95% CI 0.11 to 0.23). However, compared to other countries, for Nordic countries the attenuation of health inequalities was small and their relative standing did not improve. Results for women and men were similar, however class inequalities tended to be stronger in women.

**CONCLUSIONS:** Adjusting for financial strain and labour force status attenuates a high proportion of health inequalities in some counties, but attenuation in Nordic countries is modest and we need to investigate other explanations for their relative large inequalities.

**57282**

**READY, WILLING AND ABLE: THE DETERMINANTS OF USING MODERN CONTRACEPTION IN EUROPE**

*Rozemarijn Dereuddre*

*Bart van de Putte*

*Piet Bracke*

University of Ghent, Belgium

**INTRODUCTION:** Although no European country has a fertility rate above replacement level, contraceptive behaviour varies in great extent. Central and Eastern Europe largely relies on withdrawal, safe period method and abortion to control fertility, while Western Europe has easily accessible modern contraceptives.

**OBJECTIVES:** This study aimed to identify the determinants of using no, traditional or modern contraceptives and to understand the cross-national diversity in contraceptive behaviour. We relied on Coale's (1973) framework by hypothesizing that only couples who are ready, willing and able to delay pregnancy will use modern contraception. Also country-level characteristics linked to these preconditions were added to the model.

**METHODS:** We used data of the Generations and Gender Survey of four Western, and six Central and Eastern European countries (2004-2008; N=27,600). As the dependent variable consists of three categories (no, traditional or modern contraceptives), multinomial multilevel analyses were performed.

**RESULTS:** The descriptive results confirm high prevalence of not using any contraceptives or relying on traditional methods in Central and Eastern Europe. Analyses indicate that the three hypothesized preconditions are especially important in predicting whether couples use no or modern contraceptives. In all countries, respondents who assign higher costs to having a child, experience less social pressure, and are higher educated and have a higher income are more likely to use modern contraception as compared to not using anything. Furthermore, there are clear indications that society's family orientation, prevailing norms concerning contraception and having children, and availability of contraceptives explain part of the differences in contraceptive use.

**CONCLUSIONS:** The implementation of Coale's Ready, Willing and Able formulation serves as a fruitful framework to integrate socio-economic, cultural and technological factors in the analysis of contraceptive use patterns. Our results add to research that indicates the need of an integrated and comprehensive reproductive health policy.

## **Session 7B: INFORMAL CAREGIVING III**

**Chair: Sara Arber, University of Surrey, UK**

**57122**

### **CORRELATION BETWEEN SOCIODEMOGRAPHIC CHARACTERISTICS AND PARENTAL HEALTH LITERACY IN DIFFERENT REGIONS OF HUNGARY**

*Zsófia Gács<sup>1</sup>*

*K. Berend<sup>2</sup>*

*G. Csanádi<sup>3</sup>*

*A. Csizmady<sup>3</sup>*

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<sup>2</sup>Family Doctors' Office, District XII, Hungary

<sup>3</sup>Faculty of Social Sciences, Eötvös Loránd University, Hungary

**INTRODUCTION:** Parents' knowledge and misconceptions on health affect the health and illnesses of their children. Parental health literacy (PHL) is thus an important predisposing factor in pediatrics. Still, there's no proper instrument for the measurement of PHL in Hungarian. Nor is it properly understood which factors influence one's PHL in different sociodemographic subpopulations.

**METHODS:** For assessing PHL a novel questionnaire was developed using validated English tests and data collected from parents, pediatricians, sociologists. It consists of a 'self-confidence score' characterizing one's ability to make a decision alone in child-care situations, a 'knowledge-score' (i.e. the exact knowledge) and a sociodemographic characteristic-sheet. The test was used in a pilot study in seven subpopulations in Hungary, two of which live in different districts of the capital (Budapest), one live in a med-sized city (Esztergom), four in rural areas.

**RESULTS:** 103 tests were filled in, 60 in Budapest, 43 in the other regions. The mean for the knowledge-score was 66,7 % (dev. 13,4); the self-confidence score was 78 % (dev. 9,8). The correlation between the two variables shows  $r^2=0,107$ . Strong possibilities presume that education have a stronger effect on knowledge-score, whereas the number of offspring, presence of the grandparents, size of the city have milder effect in influencing the scores.

**CONCLUSIONS:** The studied correlations between PHL and sociodemographic factors will help us to properly analyze factors influencing children's health. Studying PHL of children with chronic diseases and its correlation with the child's condition may identify 'new therapeutic options' which could be improved by education.

**59173**

### **INFLUENCE OF CAREGIVING ON SLEEP QUALITY IN WORKING LIFE AND LATER LIFE**

*Sara Arber*

University of Surrey, UK

**INTRODUCTION:** The impact of providing care for older or disabled relatives has been widely studied, but limited attention has been paid to how caregiving influences the sleep quality of carers using large-scale nationally representative surveys. This paper examines how caregiving is associated with sleep quality in working life and in later life.

**METHODS:** The paper analyses the British 'Understanding Society' survey for 2009 to compare older people ( $n=3131$ , aged  $>65$ ) with those aged 20-64 ( $n=11355$ )(1). We analyse how number of hours of co-resident and non-resident caregiving per week is associated with self-reported sleep quality using separate nested logistic regression models for each age group, that included gender, age, marital status, hours of caregiving, education, housing tenure, employment status, self-perceived health and health limitations.

**RESULTS:** Co-resident caregiving is strongly linked to poor sleep. In working life, there is a linear association of hours spent caregiving with poorer quality sleep, which becomes attenuated following adjustment for employment status and health status of caregiver. However, above age 65, those caregiving

for more than 100 hours per week have worse sleep (OR=2.5) compared to non-caregivers, which is not moderated following adjustment for co-variables. Women's sleep was more adversely affected by caregiving than men's, especially in working life. Non-resident caregiving was not associated with sleep quality. CONCLUSIONS: There is a need for greater recognition of the adverse effects of co-resident caregiving on the sleep and well-being of caregivers, as well as how these effects may vary at different life course stages. 1. 'SomnIA, Sleep in Ageing', New Dynamics of Ageing initiative, supported by AHRC, BBSRC, EPSRC, ESRC and MRC (RES-339-25-0009).

**67244**

**SUPPORT MEASURES FOR INFORMAL CAREGIVERS. QUALITATIVE STUDY IN FIVE EUROPEAN COUNTRIES**

*Evi Willemse*

University of Antwerpen, Belgium

INTRODUCTION: Informal caregivers (ICG) are important stakeholders in future supply of care for the dependant elderly (DEP). As of today they remain a central piece in the long-term care systems in all European countries. The aim of the study is to describe the effects and experiences regarding policy measures to support ICG in different European countries.

METHODS: An empirical qualitative research using an embedded multiple case-study design was used. Semi-structured interviews were done in 5 countries (Belgium, France, Germany, the Netherlands and Luxembourg) with 38 ICG, with at least 5 ICG living in each geographical region.

RESULTS: In all regions, ICG provide personal care or support and insure the continuity of care through coordination of services provided by professionals. ICG are usually informed on the services available for the DEP. Timely access to reliable proactive information for the ICG seems one of the key issues that is lacking at the moment in Belgium in contrast with the cases abroad.

CONCLUSIONS: The formal services provided to the DEP have the most impact in allowing the ICG to care for the DEP at home. ICG seem to use support measures available to them, to ensure they can respond to the care demands as well as to the continuity of care provided by professionals. Compared with other countries, fragmentation of the system in Belgium is apparent. The ICG find it difficult to navigate through the system. In other countries, information seems to be given more timely. The ICG is a key piece in the coordination of care and therefore in the continuity of the care provided to the DEP.

**Session 7C: LIFE-STYLE**

**Chair: Anu Katainen, University of Helsinki, Finland**

**59401**

**SOCIOCULTURAL DIMENSIONS OF SOCIOECONOMIC HEALTH DISPARITIES: FOCUS ON AGENCY**

*Antti Maunu*

Finnish Association for Substance Abuse Prevention, Finland

INTRODUCTION: In Finland socioeconomic health disparities are relatively wide. In the highest income quintile men's life expectancy is 12,5 years longer than in the lowest. At the same time, income gap in Finland is smaller than in OECD countries on average, speaking on behalf of cultural and social factors behind health inequalities. However, a problem in mainstream health research is that there are no satisfying theoretical or methodological means for analysing the cultural underpinnings of health disparities. The field of health research is dominated by two types of explanative models that tend to view health disparities either as consequences of overriding material circumstances or as results of different individual choices or characteristics.

METHOD: In our view, both of the aforementioned explanations are wrong – alone. Rather, we approach all human agency as an interplay between structural conditions and individual characteristics. In a sociological perspective, agency also presupposes a culture: the agent must have some collectively shared horizon(s) of meanings and values in order to make her individual action meaningful and communicable in the first place. In our presentation we ask, first, if there are some social or cultural elements in lower socioeconomic classes' agency that makes them more vulnerable to sickness and ill-being – or if there are other elements in higher classes' agency that increase their resilience. Second, we present conceptual tools

for analysing the sociocultural dimensions of agency and their possible impact on health and health-related behaviour.

**RESULTS AND CONCLUSIONS:** We show that there are considerable differences in different socioeconomic groups' forms and logics of agency in Finland. We also claim that these factors can explain both why different socioeconomic groups have different resources for health and health-related behaviour, on the one hand, and why they make different health-related choices, on the other.

**57209**

### **HOW LIFESTYLE BECAME THE DOMINANT EXPLANATION FOR TYPE 2 DIABETES: A HISTORICAL ANALYSIS.**

*Shane O'Donnell*

University College Dublin, Ireland

Since the emergence of diabetes as a public health threat around the middle of the 20th century, accounts of disease causation have focused on lifestyle and/or genetics, while the role of broader structural issues, such as psychosocial distress, were downplayed. Yet, in the years prior to this emergence, when diabetes remained the preserve of the wealthy, medical experts drew upon multiple explanations for the origins of the condition, with the role of social organisation and interplay between mind, body and environment among the most popular. This paper is based on a discourse analysis of the writings of the most prominent diabetes experts between 1870 and 1950. It aims to highlight why lifestyle, and not social organisation, became the prevailing research interest as diabetes made the transition from being a disease of the rich to one of the poor. The results show that until the 1920s, diabetes was predominantly characterised as a nervous malady caused by overwork and job strain. However, this applied only to those who held important positions in society and therefore less advanced 'races' (e.g. working class or aboriginal populations) were understood to be relatively immune. It was not until the 1940s, when diabetes became more common among those lower down the social hierarchy, that lifestyle became the dominant explanation. The paper concludes by arguing that this shift in the definition of the illness was shaped by the dynamics of class relations rather than any new forms of scientific evidence which may have developed at the time.

**59373**

### **PHARMACEUTICALISATION OF DRUG CULTURES? POLYDRUG USE AND USER NETWORKS ON THE INTERNET**

*Sanna Rönkä<sup>1, 2</sup>*

*Anu Katainen<sup>1</sup>*

<sup>1</sup> Department of Social Research, University of Helsinki, Finland

<sup>2</sup> Finnish Foundation of Alcohol Studies, Finland

**INTRODUCTION:** The non-medical use of prescription pharmaceuticals is a growing phenomenon with increasing health-related harms. In Finland, this shows among others in drug related deaths. However, there are still very few sociological empirical studies available on the subject. The aim of our paper is to examine the user expertise of polydrug use and the role of pharmaceuticals in current drug scenes.

**METHOD:** The data consists of discussion threads on a Finnish drug users' discussion forum. Among the members, experimenters, recreational users and users with dependence can be identified. As a theoretically oriented methodological tool we apply actor network theory (ANT) which enables the analysis of the linkages between users, pharmaceuticals and other substances and the effects of the drug itself.

**RESULTS:** Illicit drugs, research chemicals, designer drugs and pharmaceutical products are interchangeable for members of the forum when it comes to effects of the substance. What motivates the pharmaceutical use and mixing them with other substances is the known quality of the drug. Pharmaceuticals make it easier to optimize the desired level of intoxication and to experiment with user's own drug related competences. The discussion forum serves as a medium for sharing own expertise and experiences related to drug use. The members use chemical and neurological terms to describe the substances and their effects in the brain. Internet, pharmacies and medical doctors are actors in the field, thus creating a new kind of infrastructure of drug use.

**CONCLUSIONS:** The drug use has been pharmaceuticalised and there are signs of "folk neurology" in drug cultures. The phenomenon cannot be understood from a single enhancement, pleasure or abuse paradigm but a more coherent model is needed.

59426

**SOCIAL REPRESENTATIONS OF HEALTH IN RELATION TO HEALTH-RELATED-LIFESTYLE OF THE MIDDLE CLASS IN POLAND**

*Agnieszka Borowiec*

*Izabella Ignowska*

*Zofia Słońska*

The Gardinal Stefan Wyszyński Institute of Cardiology, Poland

**INTRODUCTION:** In developed societies, the middle class is considered not only to lead a healthy lifestyle but also to disseminate such lifestyle in the society. Some special way of perceiving health seems to be factor driving the healthy lifestyle of the middle class. The way of perceiving health can be understood as a social representation of health which, according to theory, influences people's health-related behaviour. The study aimed to identify the social representations of health among Warsaw's middle class and to verify the hypothesis that some dimensions of the social representation of health have an effect on a healthy lifestyle.

**METHODS:** The study comprised six FGIs and a survey on a quota-based sample of 500 respondents belonging to the middle class in Poland's capital city.

**RESULTS:** A total of five dimensions of social representation of health were identified: a healthy lifestyle, lack of diseases and good condition of the body, capability to function unassisted in everyday life, good psychosocial functioning, and positive health self-perception.

**CONCLUSIONS:** If health is understood as a healthy lifestyle, this conduces to a lifestyle comprising unambiguously healthy behaviours. People who understand health as the capability to function unassisted in everyday life and as positive health self-perception are less likely to undergo preventive medical check-ups. Other dimensions are associated with lifestyles which involves healthy as well as unhealthy behaviours. The results confirm the initial assumption that some dimensions of the social representation of health do, indeed, have an effect on the healthy lifestyle among Warsaw's middle class.

**Session 7D: HEALTH AND IMMIGRANTS II**

**Chair:** Annika Lillrank, University of Helsinki, Finland

59654

**REFUGEE WOMEN'S HEALTH CARE EXPERIENCES REGARDING PREGNANCY AND BIRTH IN FINLAND**

*Annika Lillrank*

Swedish School of Social Science, University of Helsinki, Finland

This paper explores how refugee women experience their pregnancy and birth giving in interaction with the Finnish maternity care professionals. We have limited knowledge of these women's pregnancy and birth giving experiences. These women usually arrive from poor circumstances where the maternal health care is not well developed (Malin 2011). What kinds of health promoting resources and survival strategies refugee women mobilize to carry out motherhood (Cowen Rosa & Suong 2009), when they socially engage themselves into the Finnish society? This study departs from the salutogenic theory that defines human beings as resourceful agent. The emphasis lies in trust that resources are available if needed and that they are sufficient to take care of their demands. In this study 11 women who came from Russian, Somalia, Afghanistan, and Irak were interviewed with an interpreter. My criteria for selecting informants were that they are 1) refugee women who have been granted a residence permit in Finland, 2) who have lived at least two years in Finland, and 3) who currently take care of their child(ren) at home. Five women considered the received care as good. Four women with dramatic experiences were able to develop trust in the care providers. Two women were traumatized by the care providers' inability to recognize their need of care. The main findings highlight that these refugee women's individual ability to develop trust was essential. The ethnic background of these women could not only explain their experiences. This supports the salutogenic theory that emphasizes the importance of individual resources that enables human beings to solve problems and use available resources to develop a sense of wellbeing.



57321

## THE HEALTH STATUS OF MIGRANT WOMEN IN LOMBARDY: RIGHTS AND ACCESS TO HEALTH CARE SERVICES

*Lia Lombardi*

University of Milan; ISMU Foundation, Italy

**INTRODUCTION:** This study relates with the socio-economic determinants to health conditions of migrant women in Lombardy (the Italian region with the highest of immigrants - 24%). It is part of a larger study that considers both the national and international aspects of the health of migrant women, interconnected with the social conditions and risk factors related to migration patterns and to the gender gap. The data gathered and the analysis of the hospital admissions forms, brought to light: the emergence of new diseases and risk factors, and their sexual and reproductive health (pregnancy, childbirth, abortion, sexually transmitted diseases). We explored the rights of migrant women and their accessibility to health services (e.g. the absence of migrant women in "cancer prevention programmes").

**METHODS:** To conduct this research, the methodological approach was of an integrated type. Both qualitative and quantitative tools were used. To analyse the health status of immigrant women in Lombardy we used the data of hospital admissions and the ISMU Foundation annual reports. The in-depth interviews on access to "cancer prevention programmes" were carried out with professionals of different nationalities (gynaecologists, midwives and cultural mediators) who operate in Lombardy.

**RESULTS AND CONCLUSIONS:** We can observe a good level of care concerning the area of reproductive health of migrant women. Yet, the spread of HIV and abortion rates remain high for migrant women from Latin America, Eastern Europe and Sub-Saharan Africa. In addition, specific risks and lack of access to health services by irregular migrant women were found. Furthermore the number of children and foreign adolescents admitted to hospitals is twice the amount observed of young Italian people.

55995

## THE ROLE OF PHYSICAL FUNCTIONING IN EXPLAINING THE WORK ABILITY OF MIGRANTS IN FINLAND

*Shadia Rask<sup>1</sup>*

*Anu E. Castaneda<sup>1</sup>*

*Päivi Sainio<sup>1</sup>*

*Sari Stenholm<sup>1, 2</sup>*

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**INTRODUCTION:** The role that physical functioning has in the self-reported work ability of migrants is unknown. This study aims to examine the association between physical functioning and work ability in Russian, Somali and Kurdish migrants.

**METHODS:** The study uses data from the Migrant Health and Wellbeing Study (Maamu), a cross-sectional interview and health examination survey conducted in Finland in 2010–12. The sample comprises 3,000 persons of Russian, Somali or Kurdish origin aged 18–64 years. Of Russians 70%, of Kurds 63% and of Somalis 51% participated. The dependent variables include self-reported work ability now and in the coming two years. Independent variables include demographic variables (age, sex, education level, employment status, time in Finland, ethnicity), and self-reported mobility limitation (difficulties in climbing stairs without resting or walking 500 m). Logistic regression analysis will be used to investigate the association between mobility limitation and work ability, controlling for employment status.

**RESULTS:** According to preliminary results, 10% of Russians, 28% of Somalis and 35% of Kurds reported difficulties in climbing stairs. Of Somalis 13%, of Russians 15% and of Kurds 29% reported reduced work ability. Somalis expected their work ability to improve more often (87%) than Kurds (41%) and Russians (35%). The unemployment rate was 24% among Russians and 28% among Kurds and Somalis.

**CONCLUSIONS:** Unemployment and mobility limitations were common among Russians, Somalis and Kurds, but most are optimistic about their work ability. Further analyses of the associations between these phenomena are available by August 2014.



## **Session 7E: HEALTH PROMOTION AND SERVICES II**

**Chair:** Rudolf Forster, Ludwig Boltzmann Institut Health Promotion Research, Vienna, Austria

**56950**

### **CAM PRACTITIONERS' STRATEGIES TO ACHIEVE OCCUPATIONAL CLOSURE IN THE PORTUGUESE HEALTHCARE SYSTEM**

*Joana Almeida*

Centre of Criminology & Sociology, Royal Holloway University of London, UK

**INTRODUCTION:** The aim of this paper is to analyse the main strategies of closure that have been recently enacted by complementary and alternative medicine (CAM) practitioners to achieve occupational control over work domains in the Portuguese healthcare market. Abbott's jurisdictional vacancy theory, Neo-Weberian occupational closure theory, and Light's countervailing power concept, are proposed as a framework for analysis.

**METHODS:** Acupuncture and homeopathy will be presented as case studies. Data are derived from in-depth interviews with 10 non-medically trained acupuncturists and 10 non-medically trained homeopaths.

**RESULTS:** The data analysis suggested that expressing 'countervailing values', professionalising and forming alliances with the medical profession have been the main strategies used by CAM practitioners in an attempt to achieve inclusion and hence closure. It will be argued that a further outcome of these strategies is the promotion of CAM treatments and solutions to human problems, sometimes as complementary, other times as alternative, to medical solutions.

**CONCLUSIONS:** The promotion of CAM can thus impact on the medicalisation process of certain conditions, and its sociological analysis can contribute to take the medicalisation vs demedicalisation debate towards unexplored theoretical grounds.

**56048**

### **EARLY ENTRANCE TO CHILDCARE AND CHANGING CHILDCARE PLACES ASSOCIATED WITH CHILDREN'S OVERWEIGHT IN FINLAND**

*Eva Roos<sup>1, 3</sup>*

*Retta Lehto<sup>1</sup>*

*Päivi Mäki<sup>2</sup>*

*Carola Ray<sup>1</sup>*

*Tiina Laatikainen<sup>2</sup>*

<sup>1</sup> Folkhälsan Research Center, Finland

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<sup>3</sup> Department of Public Health, Hjelt Institute, University of Helsinki, Finland

**INTRODUCTION:** Different forms of non-parental childcare have been found associated with overweight in children in some, but not all studies. Studies on the matter are mainly American. Objective of this study was to examine different aspects of childcare use and overweight in Finland.

**METHODS:** The cross-sectional data consists of 1684 3- and 5-year-old children participating in the Child Health Monitoring Development project study (LATE-project), conducted in 2007–2009 in Finland. Children's weight and height was measured at health check-ups by trained nurses and parents completed a questionnaire including questions on childcare use. Overweight (including obesity) was defined according to international BMI limits.

**RESULTS:** Entering childcare under one year of age and having had many childcare places were associated with increased risk of overweight among 5-year-old Finnish children. Neither current form of childcare nor current hours at childcare were associated with overweight. The results were adjusted for birth weight, family background variables and child's PA, TV viewing and eating behavior.

**CONCLUSIONS:** Entering childcare very early and having had many childcare places were associated with overweight even when adjusting for family SES and child's energy balance-related behaviors. Reasons for these associations can only be speculated. Stress may play a role.

56737

**LAY PARTICIPATION IN HEALTH-RELATED DECISIONS: A SELECTIVE REVIEW OF FRAMEWORKS AND AN ALTERNATIVE CONCEPTUALIZATION**

*Rudolf Forster*

*Ludwig Marent*

Ludwig Boltzmann Institut Health Promotion Research, Austria

**INTRODUCTION:** Patient and public participation has become a key principle in health policy, provision and research. It is argued as a strategy to democratize health-related decisions, to foster empowerment and to enhance the responsiveness of health programmes. Yet looking at the state of the scientific debate about participation a rather critical stance prevails: Many writers point to conceptual vagueness and normative substantiation, leading to inconsistency and instrumentalization in participatory practice and a lack of evidence in research.

**METHODS AND OBJECTIVES:** This paper undertakes a selective review of prominent frameworks of participation, discusses key questions and sums up critical debates. It aims to suggest theoretically founded avenues for further conceptualization.

**RESULTS:** Across many frameworks of participation in health-related decisions four essential perspectives can be traced: goals, roles, issues – which we consider as “situation-dependent” – and levels, seen as more general. “Levels” relate to the degree of influence on decision-making: Most frameworks adhere to a hierarchical approach, emphasizing the “quantity” of power as the core of participation. In contrast to understanding participation solely as power-struggle and taking up recent critique on the lack of complexity we refer to sociological theories of communication and portray participation as a social process consisting of three dimensions: a factual dimension (relating to knowledge exchange), a social dimension (relating to decision power and control) and a temporal dimension (relating to decision phases).

**CONCLUSIONS:** These three dimensions contribute to a more complex and generic understanding to observe, plan and evaluate different forms of lay participation in health-related decisions.

54366

**CANCER FUNDRAISING: ADDRESSING VULNERABILITIES?**

*Rosaline Barbour*

Open University, UK

**INTRODUCTION:** Hardly a week goes by without a request for sponsorship from a friend or colleague engaged in fund-raising events – whether these are marathons, fun runs, or even the growing of a moustache. Campaigns focusing on other conditions notwithstanding, cancer fundraising still accounts for the majority of such activities. However, the phenomenon has largely escaped sociological scrutiny - apart from documenting the support provided, and responses of service providers and policy makers. This paper brings a variety of theoretical perspectives to bear in seeking to provide a more nuanced understanding. It seeks to go beyond the critique of fundraising as the 'commodification of compassion', in order to attempt to explain the burgeoning of public engagement, and asks what might be at stake besides the raising of money. In particular it asks whether involvement in fundraising can afford a means for addressing and even resolving feelings of vulnerability.

**METHODS:** It examines the usefulness for of a range of theoretical frameworks, including those relating to the genesis and development of ‘embodied health movements’ (EHMs) (including ‘spillover’ to adjacent groups and the potential for dilution of the message), and ideas about ‘intimate citizenship’. EHMs are characterised by the central role accorded the body – both as a site subjected to conceived threats and as a vector for fundraising, drawing on and reproducing relationships of reciprocity via networks. Taking part in fundraising events, involving celebration of survival, enactment of memorialisation and transformation of fear and shame into empowerment may produce something akin to the ‘collective conscience’ conceived of by Durkheim, but is this fleeting or capable of being sustained?

**CONCLUSIONS:** This review raises interesting questions about the relationship between the personal and the political; personal and collective achievement; ‘intimate citizenship’; and the potential tensions between achieving catharsis at an individual level and enacting resistance at a group level.

**Session 7F: WORK AND WELL-BEING IV: Working conditions**  
**Chair: Tea Lallukka, Finnish Institute of Occupational Health, Finland**

**59318**

**DECREASING JOB QUALITY IN EUROPE? THE EVOLUTION OF JOB STRAIN AND  
ERGONOMIC STRAIN BETWEEN 1995 AND 2010**

*Christophe Vanroelen*

Department of Sociology, Vrije Universiteit Brussel, Belgium

**INTRODUCTION:** Disability among the working-aged population is on the rise throughout Europe. Psychiatric disorders and musculoskeletal problems are the most important causes of disability, while important work-related drivers of these conditions are psychosocial stress and adverse ergonomic working conditions. This paper offers a detailed investigation of the evolution of psychosocial and ergonomic strain exposures among European workers during the period 1995-2010.

**METHODS:** Data from EUROFOUND's cross-sectional European Working Conditions Surveys is used (1995, 2000/1, 2005, 2010). In the total sample of 101.161 wage-earners, information for each wave of the survey is available for 15 countries. For 13 additional countries data for one to three surveys is included. Job strain (psychosocial stress) and ergonomic strain are investigated as the main outcomes. Descriptive and multilevel analyses are performed, using country-years and countries as second and third level units of analysis.

**RESULTS:** Preliminary results are showing considerable country variation in the exposure to job strain and ergonomic strain. For job strain a clear overall increase over time can be seen, which is even stronger when the sample is restricted to the 15 countries with information from 1995 onwards. Also a moderate but significant increase over time in ergonomic demands is found, both in the 15 countries with complete information and in the total of 28 countries. Further analyses should test whether controlling for individual and country-level factors significantly modifies the associations found.

**CONCLUSIONS:** These preliminary results are suggesting the worsening of two crucial quality of work indicators in European workers. Decreasing quality of work could be a powerful explanation for rising disability levels in the working-aged population. Further research should shed a light on potential causes.

**57005**

**INEQUALITY OF EXPOSURE TO OCCUPATIONAL RISKS IN EUROPE AND THE THEORY  
OF EQUALISING DIFFERENCES**

*Diego Montano*

Faculty of Medicine, Duesseldorf University, Germany

**INTRODUCTION:** Physical, chemical and biological risks still account for a substantial proportion of work-related diseases and fatalities in Europe. Frequently, these risks are concentrated on specific occupational groups and associated with chronic illnesses such as musculoskeletal disorders, cancers and allergies. It has been argued in the framework of the theory of equalising differences that high work-related risks are compensated with increased wages. The objective of this presentation is to review this hypothesis by analysing survey data from the European Working Conditions Survey (EWCS).

**METHODS:** In a first step, the major ISCO occupational groups associated with increased levels of exposure are identified based on current knowledge on carcinogenic, sensitising and reprotoxic substances, and on prevalence estimates of musculoskeletal disorders. In a second step, a generalised linear regression model is estimated from EWCS 2005 data. The dependent variable is the average monthly net income from the main paid job. Independent variables include work-related physical and chemical risks, educational level, ISCO groups, and company size, among others.

**RESULTS:** Net income differences are positively related to education, company size and working hours. Wages are substantially lower for those exposed to occupational hazards compared to those in comparable ISCO groups with lower levels of exposure.

**CONCLUSIONS:** Results suggest that wage differences are not compensating risk differences but rather remunerating human capital accumulation and may reflect differences of bargaining power between workers and employers.

56787

**DOES STRESSFUL WORK CONTRIBUTE TOWARDS EXPLAINING SOCIOECONOMIC DIFFERENCES IN MENTAL HEALTH? A SYSTEMATIC ANALYSIS**

*Hanno Hoven<sup>1, 2</sup>*

*Morten Wahrendorf<sup>2</sup>*

*Johannes Siegrist<sup>1</sup>*

<sup>1</sup> Faculty of Medicine, University of Duesseldorf, Germany

<sup>2</sup> Centre for Health and Society, institute for Medical Sociology, University of Duesseldorf, Germany

**INTRODUCTION:** Evidence on the role of work stress in mediating the association of socio-economic position (SEP) with mental health is still inconclusive, partly due to a lack of consistent and theory-based measures and a lack of longitudinal study designs.

**METHODS:** In this contribution, we study associations between three complementary measures of SEP based on occupation (occupational class, occupational status and occupational skill level) and mental health (in terms of depressive symptoms). Additionally, we explore to what extent these associations are mediated by a stressful psychosocial work environment (as measured by the effort-reward imbalance model). Analyses are based on longitudinal data from three waves of the Survey of Health, Ageing and Retirement in Europe (SHARE), collected between 2004 and 2011, with information on some 5000 employed men and women aged 50 and older across 10 European countries.

**RESULTS:** For all three measures of occupational position, findings demonstrate a social gradient of mental health, with elevated risks among working people in lower occupational positions. Importantly, results of multivariate path analyses reveal a partial mediation by work stress for each one of the three SEP measures.

**CONCLUSIONS:** Our findings document a relevant contribution of work stress towards explaining socioeconomic differences in mental health. In terms of policy implications, investments into health-promoting working conditions might contribute to improved mental health, in particular among workers in low occupational positions.

56906

**OCCUPATIONAL INEQUALITIES IN ENVIRONMENTAL TOBACCO SMOKE EXPOSURE AT WORK: EUROPEAN COMPARISONS**

*Nico Dragano*

Institute for Medical Sociology, Centre for Health and Society, Medical Faculty, University of Düsseldorf, Germany

**INTRODUCTION:** An unequal distribution of occupational risk factors, such as environmental tobacco smoke at work (ETSW), can aggravate social inequalities in health. Effective occupational safety and health (OSH) regulations may help to reduce these inequalities and ETSW is an interesting example to study the impact of regulatory action. Many European countries have introduced regulations regarding workplace smoking in recent years, but the specific arrangements differ substantially (e.g. smoking bans vs. negotiated agreements). The aim of this study is to describe systematically occupational differences in ETSW in European countries and to explore the possible influence of OSH policies.

**METHODS:** This comparative study uses data from 30.656 employees interviewed for the European Working Conditions Survey 2010 wave in 34 countries. To analyse trends, data from the 2005 wave were added (only EU-15 countries). Exposure towards environmental tobacco smoke at work was self-reported. ETSW prevalence was compared for various individual level characteristics (e.g. education, occupational position, type of contract) in multilevel regression models. Stratified analyses were conducted by single countries to identify differences in inequalities. Country information on anti-smoking policies was taken from EU reports.

**RESULTS:** Overall prevalence of ETSW decreased between 2005 and 2010 suggesting improvements in regulatory practice. However, pooled analyses of 2010 data showed exposure differences between occupational groups. Higher exposure was observed in lower educated workers, in the industrial sector, in craft workers and elementary occupations, in workers without contract and in small-size organizations. Country comparisons indicate that inequalities are smaller in countries with stricter anti-smoking policies.

**DISCUSSIONS:** Results suggest that regulation of smoking at work effectively reduces exposure towards passive smoke. Despite an absolute reduction in exposure rates occupational inequalities seem to persist in

many countries. Supplementing regulatory action by health promotion for vulnerable groups may thus enhance efforts to reduce existing inequalities.

## **PARALLEL SESSIONS VIII**

### **SATURDAY 30 August at 10.30 - 12.00**

#### **Session 8A: MORTALITY II**

**Chair:** Netta Mäki, University of Helsinki, Finland

**56063**

#### **PREMATURE MORTALITY AFTER SUICIDE ATTEMPT AND THE RISK IN RELATION TO SOCIOECONOMIC STATUS IN FINLAND**

*Netta Mäki*

University of Helsinki, Finland

**INTRODUCTION:** Several studies have shown that individuals with a history of suicide attempt form a high-risk mortality group, and completed suicide is the main cause of death among them. Furthermore, a few studies suggest that even though low socioeconomic status increases suicide in general population, the association between socioeconomic status and suicide is non-existent or even reversed in suicide attempt population. However, this association is still little studied.

**DATA AND METHODS:** Data come from population-register data files with an 11% nationally representative sample all of the Finns between the end of 1988 and 2007 with a random oversample of 80% of all deaths during the period and a linkage with information on causes of hospitalization.

**RESULTS:** The highest differences in mortality between the general and suicide attempt populations were for external causes of death, especially for suicide, but mortality for many diseases was also higher in the suicide attempt population. Mortality was especially high during the first year following the attempt, for example, total mortality was over 8-fold higher. In the general population, socioeconomic status was inversely associated with total and suicide mortality, but in the suicide attempt population, the association was either weaker (all cause mortality) or direct (suicide).

**CONCLUSIONS:** In suicide attempt population those with a high socioeconomic status form the most vulnerable groups possibly because of worse mental health status before being hospitalized or because the admission is more stigmatising for them. Suicide prevention should focus on designing adequate aftercare following attempts.

**56763**

#### **NEVER MARRIED, EVER MARRIED, ALWAYS MARRIED? MARITAL HISTORIES AND RISK OF MI INCIDENCE AND FATALITY**

*Fanny Kilpi*

*H. Konttinen*

*K. Silventoinen*

*P. Martikainen*

Department of Social Research, University of Helsinki, Finland

**INTRODUCTION:** Marital status is associated with several health outcomes. Finnish register-based data provides an opportunity to study in more detail how different marital histories are associated with both the onset and course of myocardial infarction (MI), which aids in understanding how marriage and divorce influence coronary health and mortality.

**METHODS:** The marital histories of a sample of men and women aged 40-60 in 1995 (n=301,415) were categorised into the long-term married (first/subsequent marriage), newly-married (within 5 years before baseline), divorced, widowed and never married. MI in the follow up (1996-2007) was identified from linkages with the cause of death and hospital discharge registers. The associations of marital histories with MI incidence and subsequent fatality were analysed with Cox regression. Hazard ratios (HR) were estimated in models adjusted for age and indicators of socioeconomic position.

**PRELIMINARY RESULTS:** First long-term marriage was associated with a reduced risk of MI incidence and fatality, but with sex differences in the risks associated with specific marital histories. Divorced men



had an increased risk of both incidence (HR=1.21) and fatality (HR=1.43) compared to the long-term married. Women who were in a long-term marriage that wasn't their first had a significantly increased risk of incidence (HR=1.37), but not fatality. The never married had the greatest risks of long-term fatality in both sexes.

**CONCLUSIONS:** The results highlight the protective effects of marriage as well as some notable differences between men and women in the influence of marital histories, such as the greater risks incurred by divorce for men.

**57206**

### **EDUCATIONAL INEQUALITIES IN MORTALITY IN SWEDEN 1990-2009: THE ROLE OF FAMILY TYPE AND INCOME**

*Olof Östergren*

Centre for Health Equity Studies (CHESS), Stockholm University, Sweden

Department of Sociology, Karolinska Institutet, Stockholm University, Sweden

**INTRODUCTION:** Although absolute levels of mortality have decreased among Swedish men and women in recent decades, educational inequalities in mortality have increased. Education influences health in multiple ways, for example by acting as a determinant of other socioeconomic factors and by providing the individual with skills that promote health. The aim of this study is to disentangle the role of income and family type in educational inequalities in mortality in Sweden during 1990-2009, focusing on gender differences.

**METHODS:** Data on individuals born in Sweden between the ages of 30 and 74 was collected from total population registries, covering a total of 529 275 deaths and 729 million person months. Temporary life expectancies (ages 30-74) by education were calculated using life tables and incidence rate ratios were estimated with Poisson regression with robust standard errors.

**RESULTS AND CONCLUSIONS:** Temporary life expectancy improved among all groups except low educated women. Relative educational inequalities in mortality (IRRs) increased from 1.79 to 1.98 among men and from 1.78 to 2.10 among women. Variation in family type explained some of the inequalities among men, but not among women, and did not contribute to the trend. Variation in income explained a larger part of the educational inequalities among men compared to women and also explained the increase in educational inequalities in mortality among men and women. One possibility is that in an increasingly well-educated population, the relative position of the low educated in the labor market could become increasingly disadvantaged, leading to lower income levels which in turn influence mortality.

## **Session 8B: PROFESSIONS II: Nursing**

**Chair:** Charlotte Sercu, University of Ghent, Belgium

**57348**

### **EMPOWERMENT FIGURES OF THE NURSING PROFESSION**

*Kevin Toffel*

*Philippe Longchamp*

Haute Ecole de Santé Vaud, Lausanne, Switzerland

**INTRODUCTION:** The nursing profession can be considered as a social space which meets certain properties of the field as defined by Pierre Bourdieu. Our paper thus aims at analyzing the effects of professional positions and individual dispositions on the representations and practices of nurses.

**METHOD:** We have conducted 21 semi-directed interviews with nurses practicing throughout the Western-Switzerland region and occupying the most typical positions of the profession. The interviews were fully transcribed and subjected to a thematic category analysis.

**RESULTS:** Three ideal-typical figures come out, which contribute in particular to the struggle for the autonomy of the nursing social space. The «forward-thinkers» appear very open to types of knowledge which are exogenous to the medical field (alternative therapies, social sciences, etc.). Their « subversive » dispositions go back to their generational belonging as much as they derive from their working-class origin. The « scientists » are younger than the forward-thinkers and are generally of middle-class extraction. Having completed the new training programs (Bachelor, Master, and sometimes PhD), they drive the conversion process of exogenous knowledge into material recognized as proprietary to the Nursing



Sciences discipline. Finally, the « orthodox » are the third ideal-type. They are especially engaged in the process of spreading this knowledge among other professionals and students, thereby contributing to the establishment of a certain professional orthodoxy.

CONCLUSIONS: These three ideal-typical figures are instrumental in the empowerment process of the nursing space. The fields theory helps demonstrate, however, that the cooperation between these nurses goes hand in hand with social relationships of a competitive nature, which are a function of both their positions and their dispositions.

**55910**

### **FROM CARE TO COMPREHENSIVE AND CUSTOMIZED SOLUTIONS: THE CHANGING ROLE OF FINNISH OCCUPATIONAL HEALTH NURSES**

*Inka Koskela<sup>1</sup>*

*Patrik Nordin<sup>2</sup>*

*Päivi Husman<sup>1</sup>*

*Jan-Erik Johanson<sup>2</sup>*

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<sup>2</sup>University of Tampere, Finland

This paper deals with the changing role of the Finnish occupational health nurses due to change from a patient-oriented to sales-oriented view in the occupational health care sector. The shift in orientation means that the occupational health nurses, who earlier offered standard solutions to their customers, are now expected to provide comprehensive and customized solutions and services for their client companies. Using professional identity (Louis, 1980; Kirpal, 2004) and role conflict theories (Stryker & Statham Macke, 1978), this study examines how occupational health nurses negotiate their new role within this change process and what kind of strategies they adopt to cope with the new demands on their work. This paper combines different qualitative and quantitative data including interviews conducted with nine nurses, feedback questionnaire filled after a marketing training and nurses' work satisfaction questionnaires. Using qualitative content analysis and quantitative methods, the study shows that nurses' professional identity consists of several components, including those of care-giver, team player, expert, adviser, customer servant and sales person that partly exist simultaneously and are contradictory. There are individual differences (e.g. in age, work experience, previous occupation) in how nurses cope with these contradictory demands and how capable and willing they are to re-define their professional identity and their orientation in their daily work. Furthermore, as the company they work for emphasizes corporate social responsibility and virtue ethics, the change is even more drastic than in other companies in the occupation health care sector.

**57156**

### **ISSUES INVOLVED IN THE STRUGGLES WITHIN THE NURSING PROFESSION. A STRUCTURAL APPROACH**

*Philippe Longchamp*

*Kevin Toffel*

Haute Ecole de Santé Vaud (HESAV), Lausanne, Switzerland

INTRODUCTION: At a time when the nursing profession is undergoing significant changes in Switzerland, this paper will focus on the issues involved in the struggles arising throughout the profession. We shall consider the nursing profession as a social space which meets certain properties of the field as defined by Bourdieu. The harnessing of this theoretical framework allows to demonstrate how this profession forms a relatively autonomous system, made of specific positions displaying competitive relations among each other. Based on this theoretical framework, we tackle three questions: 1) How are the nursing profession's different sectors of activity structured? 2) How are the representations and practices structured within the profession? 3) What kind of relationship exists between the structure of the sectors and the structure of the representations and practices?

METHOD: We have conducted 21 interviews with nurses practicing throughout the Western-Switzerland region and occupying the most typical positions of the profession. The interviews were subjected to a thematic analysis.

RESULTS: The nursing profession is a social space in which two types of capital are efficient: medical capital and nursing capital. The nursing social space results from the crossing of the structure and volume

of those two forms of capital. The various positions occupied within that space tend to determine the stances that are taken by the nurses. While nurses with high medical capital tend to take relatively conservative stances, nurses with high nursing capital tend to take more subversive stances.

CONCLUSIONS: The theory of fields is usually reserved for the analysis of dominant and masculinized social spaces. Applying this conceptual tool to a heavily feminized profession casts an original light on the above issues and will hopefully nurture future discussions on the pros and cons of such an approach.

**55919**

**HOW DOES STIGMA INFLUENCE MENTAL HEALTH NURSING IDENTITIES? AN ETHNOGRAPHIC STUDY OF THE MEANING OF STIGMA FOR NURSING ROLE IDENTITIES IN TWO BELGIAN PSYCHIATRIC HOSPITALS**

*Charlotte Sercu*

*Ricardo A. Ayala*

*Piet Bracke*

Department of Sociology, Ghent University, Belgium

INTRODUCTION: Stigma constitutes a threat for professionals who work in mental health care, through their association with mental illness as a discrediting attribute. Together with nurses unclear self-perception, recent insights suggest that stigma may inform the current identity crisis within the mental health nursing profession. This article explores how stigma may give meaning to identity formation for mental health nurses. Given the context and norm dependence of stigma processes, we considered contexts of illness and care as relevant when including stigma in the study of mental health nursing identity.

METHOD: This research uses a qualitative design. Ethnographic data were gathered from 4 wards in two psychiatric hospitals in the region of Ghent (Belgium). All nurses (33) were invited to participate in the study. Participant observation and semi-structured interviews were conducted to access the meaning of being a mental health nurse in these specific care contexts and its possible interference with mental health stigma.

RESULTS AND CONCLUSIONS: The findings suggests that tackling stigma is an important motive for nurses to work in mental health care. The meaning of stigma is entangled with nurses' troublesome relationship with the medical model of care. Variations between hospitals regarding the extent to which stigma informs the professional role constructs and identity of nurses are found to be related to the degree of formalization of the nursing roles in these different hospitals. The study points to the relevance of the integration of stigma in mental health nursing identity research. Furthermore, the focus on stigma may offer an opportunity to link contexts of illness and care, and nurses' identity constructs.

**Session 8C: HEALTH AND AGEING II**

**Chair:** Claudine Burton-Jeangros, University of Geneva, Department of Sociology, Switzerland

**57208**

**SOCIAL NETWORKS CHARACTERISTICS AND QUALITY OF LIFE IN OLDER AGE. POLISH DATA BASED ON COURAGE**

*Beata Tobiasz-Adamczyk*

*Katarzyna Zawisza*

*Aleksander Galaś*

Department of Medical Sociology, Jagiellonian University Medical College, Poland

INTRODUCTION: From most common perspectives social networks have been defined as the web of identified social relationships that surround an individual person, characteristics of those linkages and the individual's perception of them. Special attention has been paid to the relationship between health status of elders and their participation in different social networks as a strategy of prevention against social disintegration and exclusion as well as against social and subjective loneliness. The aim of presentation is to assess the relations between such characteristics of ageing like saturation of social networks, social participation, loneliness and quality of life in older age.

METHOD: Survey was conducted in the representative sample of non-institutionalized adults from Polish population. Face to face interviews were performed by specially trained interviewers. Deliverables of the COURAGE were new instruments as: COURAGE Social Network Index to assess saturation of social

networks, quality of life scale (WHOQOL-AGE), social participation index. Besides the protocol also included the OSLO-3 Social Support Scale and the three-item UCLA Loneliness Scale. To assess determinants of quality of life multivariate linear regression model was used. In total 1299 participants aged 65 and over (61,1% females, 38,9% males) were included.

**RESULTS:** The results showed that higher level of social participation ( $\text{Beta}=0,15; p<0,001$ ) and social network saturation ( $\text{Beta}=0,09; p<0,001$ ) was associated with better assessment of quality of life; higher level of loneliness was related with lower assessment of quality of life ( $\text{Beta}=-0,16; p<0,001$ ). Model was adjusted for age, gender, marital status, level of education, place of living, characteristic of living place, household income, self-rated health, functional status (WHODASII) and number of people living in the household.

**CONCLUSIONS:** Presented instruments give a new opportunity to establish the relation between social network and quality of life in older age.

**56578**

### **HEALTH LOSSES AND LIFE SATISFACTION: A LONGITUDINAL STUDY OF ELDERLY ISRAELIS**

*Sara Carmel*<sup>1</sup>

*Victoria H. Raveis*<sup>2</sup>

*Hava Tovel*<sup>1</sup>

<sup>1</sup> Center for Multidisciplinary Research in Aging, Ben-Gurion University, Israel

<sup>2</sup> Psychosocial Research Unit on Health Aging and the Community, New York University College of Dentistry and Nursing, USA

**INTRODUCTION:** The purpose of this study was to evaluate the relative influences of personal resources and coping patterns (reactive and proactive) on elderly persons' wellbeing following a decline in health/functioning.

**METHOD:** At baseline (T1), 1,216 individuals were interviewed, and 1,019 one year later (T2). T2 wellbeing was evaluated by two life satisfaction scales (Neugarten et al., 1961 and Carmel, 2001).

**RESULTS:** The influence of changes in health/function, personal resources and coping patterns on T2 life satisfaction (LS) was evaluated by structural equation models resulting in satisfying fit criteria for both life-satisfaction measures. In addition to indirect effects, all the studied personal resources (functional self-efficacy, social support, economic status, satisfaction with health services) had significant direct positive effects on LS. Among the coping patterns, reengagement in new goals and having concrete plans for future care had positive effects on LS, while the proactive coping pattern of expectations for future care needs had a negative effect on LS.

**CONCLUSIONS:** The use of appropriate personal resources and coping behaviors enables elderly people to control their wellbeing even in presence of decline in health/function. Research based interventions can help older people acquire and/or strengthen some of the effective resources and coping patterns, thus promoting their wellbeing

**59387**

### **AGE-RELATED HEARING LOSS AND SUBJECTIVE WELL-BEING: THE ROLE OF SOCIAL PARTICIPATION DECLINE**

*Cláudia Andrade*

Institute of Ageing, Portugal

Age-related hearing loss (ARHL) is the most common sensory impairment in the elderly, affecting millions of people worldwide, and has been associated to reduced subjective wellbeing (Freedman et al., 2012). Reduced participation in meaningful activities due to hearing difficulties is a potential mechanism linking the disablement process to wellbeing. However, some studies suggest that ARHL leads to reduced social participation (Viljanen et al., 2013), whether others did not find such evidence (Yamada, 2012). The present study is based on the claim that this lack of consensus may be due to the fact that some social activities have not been captured by the measures used in these studies, and that people role in those activities has not been considered. Thus, we used a more complete measure of social participation, by selecting a wider range of activities which make fewer or more demands on communication. This study aims to investigate a) whether ARHL is associated with less participation in activities that require a more active role by the participant, and b) whether the social participation in such activities is a mediator of the

effect of the ARHL on subjective wellbeing and depression. This cross-sectional study is based on the 2010 data collection of the Survey of Health, Ageing and Retirement in Europe (SHARE) comprising 58489 men and women aged 50 years and older.

**71792**

#### **LIFE SATISFACTION TRAJECTORIES IN ELDERLY WOMEN LIVING IN SWITZERLAND**

*Claudine Burton-Jeangros*

University of Geneva, Department of sociology, Geneva, Switzerland

**INTRODUCTION:** While one intuitively expects quality of life to decline in older age due to diminishing social resources, declining cognitive and physical abilities, previous empirical studies reported a relative stability of quality of life over old age.

**METHODS:** To disentangle age, cohort and period effects, we examined the distribution and trajectories of life satisfaction among elderly women living in Switzerland, comparing specific age groups and cohorts. Using the Swiss Household Panel (SHP) survey data, analyses of life satisfaction distribution and trajectories were conducted for 1,402 women aged 65 to 84 years.

**RESULTS:** Findings show that the mean life satisfaction score and the prevalence of satisfied women are lower in more recent cohorts of identical ages. However their life satisfaction remains more stable over ageing than is the case in former cohorts. Results regarding determinants indicate that high education, satisfaction with income, social support, living with a partner and good self-perceived health are all positive and significant predictors of life satisfaction.

**CONCLUSIONS:** New cohorts of elderly women tend to be less satisfied with life than their predecessors, even though their living conditions have significantly improved. These results are discussed in the light of changes in living conditions and cultural expectations over time.

#### **Session 8D: GENDER AND HEALTH IV**

**Chair: Anu Katainen, University of Helsinki, Finland**

**59162**

#### **NATURE VS. TECHNOLOGY, MEDICALIZATION VS. DEMEDICALIZATION – HOME BIRTH AS SEEN BY WOMEN AND MIDWIVES**

*Antonina Doroszewska<sup>1</sup>*

*Luiza Nowakowska<sup>2</sup>*

<sup>1</sup> Faculty of Health Science, Gynaecological and Obstetrics Department, Medical University of Warsaw, Poland

<sup>2</sup> Faculty of Nursing and Health Science, Independent Medical Sociology Unit, Medical University of Lublin, Poland

**INTRODUCTION:** Medicalized model of childbirth dominates both in Poland and in many Western countries. It has become the subject of growing criticism from medical professionals and women as well. The number of home births in Poland, still low but growing each year, is an expression of such "antimedical" attitudes. The question is whether the growing interest in natural childbirth is just a trend related to the popularity of the ecological way of life, or if it is an expression of a deliberate process of demedicalization. To what extent the spread of the natural approach to childbirth is the result of active roles of women and midwives?

**METHODS:** In-depth interviews with 10 women after a home birth and 10 midwives: five assisted in home births and five were against such practices, declaring that childbirth should only take place in hospital.

**RESULTS:** Most women justified their decision by unsatisfactory prior or anticipated experience of the traditional medical system of perinatal care – eg, unjustified use of medical interventions or separation of mother from child. At the same time, midwives are much divided in their assessment of the safety of home births.

**CONCLUSIONS:** The study has shown what aspects of perinatal care are the subject of criticism, what demedicalized childbirth should look like, and what is the socio-demographic profile of families using home births. This research has been a pilot study and provides an introduction to further analysis of the optimal model of perinatal care in Poland and its comparison with other countries.

56958

**LANGUAGE OF SCIENCE AND LANGUAGE OF LOVE: THE LEGITIMATION OF INDEPENDENT MIDWIFERY PRACTICE IN RUSSIA**

*Ekaterina Borozdina*

European University at St. Petersburg, Russia

**INTRODUCTION:** The development of a “natural” approach to birth and the formation of independent midwifery practices are some of the most significant changes to contemporary Russian antenatal health care. In my research I consider the discourses employed by Russian midwives to mark their own (distinctive from medical) jurisdiction and to legitimize their status as members of an independent profession. This group is rather unorganized and diverse. For this reason, I study public representations of one of the communities of Russian independent midwives which grew around the first (and only) Russian journal of “natural” childbirth.

**METHODS:** My data was collected through participant observation at three international midwifery conferences that took place in Moscow in 2010, 2011, and 2013, organized by the journal. Alongside this data I use other public materials produced by the community under consideration: 1) issues of the journal (2009–2012); 2) materials from the journal's official website; 3) materials from the journal's official blog.

**RESULTS AND CONCLUSIONS:** I single out four core discourses that are used by Russian midwifery activists in justifying their claims for professional autonomy: medical discourse, liberal discourse, spiritual discourse, and gender discourse. The two former discourses are generally employed by midwives for external legitimation of their practice with respect to doctors, representatives of the international midwifery movement, state bureaucrats, and so on. The latter two discourses are used for the internal legitimation of independent midwifery practice. The object of this legitimation seems mainly to be the shared identity of Russian independent midwives. Feminist authors commonly acknowledge independent midwifery as a social phenomenon that subverts a patriarchal view of gender hierarchy and contributes to the empowerment of women. I examine the case of the Russian midwifery movement in order to find out if it really has this potential.

57170

**"CHILDBIRTH WITH DIGNITY" CAMPAIGN AS OPPOSITION TO "TOTALITARIAN OBSTETRICS". DEMEDICALIZATION OF PERINATAL CARE IN POLAND**

*Włodzimierz Piątkowski*

*Michał Nowakowski*

Independent Unit of Medical Sociology, Medical University of Lublin, Poland

**INTRODUCTION:** The paper presents the results of study on the "Childbirth with Dignity" campaign initiated by an ecological organization, and supported by a popular daily. The aim was to improve the conditions for giving birth in Polish hospitals. The study was to confirm whether this campaign is an example of demedicalization. Moreover, it had to answer the question of what socio-cultural processes triggered opposition to "totalitarian obstetrics".

**METHOD:** The adopted method was a qualitative and quantitative content analysis of the press. The material was 829 articles published in 1994–2014 in "Gazeta Wyborcza" (childbirth memories sent to the newspaper, information about the campaign and its results, the opinions of doctors, midwives and external experts).

**RESULTS:** Analysis of the opinions enables defining the campaign as an attempt to demedicalize childbirths. Medicalized obstetrics was accused of ignoring autonomous patients - emancipated citizens of a democratic state and consumers of health services. Driven by the free market logic this discourse was joined by professional practitioners defending their positions. Only few explicitly defended the authoritarian way of contacting patients, most sought the source of the negative image of obstetrics in its underfundedness. One could not say, however, that underlying their criticism was identification with alternative medicine and ecological ideology.

**CONCLUSIONS:** Content analysis allows the conclusion that in the context of political transformation towards free-market solutions in the 1990's, Polish "totalitarian obstetrics", inherited from the centralized, bureaucratic system of state health services, does not fit into the contemporary reality mainly because of the growing emancipation of patients.



## Session 8E: NUTRITION AND WEIGHT

**Chair:** Ritva Prättälä, National Institute for Health and Welfare (THL), Finland

**57120**

### **FROM MARGARINE TO BUTTER - PREDICTORS OF CHANGING BREAD SPREAD IN AN 11-YEAR POPULATION FOLLOW-UP**

*Ritva Prättälä*<sup>1</sup>

*T. Lallukka*<sup>2</sup>

*Esko Levälahti*<sup>1</sup>

*Tomi Mäki-Opas*<sup>1</sup>

*Satu Männistö*<sup>1</sup>

*Laura Paalanen*<sup>1</sup>

*Susanna Raulio*<sup>1</sup>

*E. Roos*<sup>3</sup>

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<sup>4</sup> University of Turku, Finland

<sup>5</sup> UKK Institute, Finland

**INTRODUCTION:** Finland is famous for major decrease in the intake of saturated fats and cardiovascular mortality since the late 1960's. However, the latest surveys show an increase in the consumption of butter and butter-vegetable oil mixture – important sources of saturated fats. We examined socio-demographic predictors of these increases.

**METHODS:** The data was collected among a representative sample of adult Finns in 2000 and 2011. Of the 5189 participants who answered the questions on bread spreads and were 30-64 years at the baseline 65% (N=3382) answered the same questions in 2011. The respondents assessed the use of bread spreads by choosing one of the following alternatives: no fat on bread, margarine (3 types), butter-vegetable oil mixture and butter. Predictors included gender, age, marital status, education and hospital district. Health behaviors, BMI and health were used as covariates. Multinomial regression models were fitted.

**RESULTS:** At the baseline 25% of men and 23% of women used butter or butter-containing spreads, in 2011 31% and 32% accordingly. The changes were mainly not associated with socio-demographic factors. Female gender was the strongest predictor of the change. Among the men, low education and living with a spouse predicted the change to butter fats.

**CONCLUSIONS:** The observed change among the women suggests that the switch to less healthy options was most common in a group that first adopted the healthier alternatives. If the other groups follow the early adopters butter consumption and consequently CVD risks may increase in Finland.

**57245**

### **WHAT DO CHILDREN DRINK WHEN THEY DO NOT RECEIVE WATER? BEVERAGE CONSUMPTION IN INDIA**

*Jasmine Fledderjohann*

University of Oxford, UK

**INTRODUCTION:** Over 1.2 billion people lack access to clean water. However, little is known about what children drink when there is no clean water. We investigated the prevalence of receiving no water and what Indian children drink instead.

**METHODS:** We analysed children's beverage consumption using representative data from India's National Family and Health Survey (NFHS-3, 2005-2006). Consumption was based on mothers' reports (n=22,668) for children aged 6-59 months (n = 30,656).

**RESULTS:** About 10% of Indian children had no water in the last 24 hours, corresponding to 12,700,000 children nationally, (95% CI: 12,260,000 to 13,200,000). Among children who received no water, 23% received breast or fresh milk and 24% consumed formula, "other liquid", juice, or two or more beverages. Children over 2 were more likely to consume non-milk beverages, including tea, coffee, and juice than those under 2 years. Those in deprived households were 16% less likely to have received water (OR=0.84;

95% CI: 0.74 to 0.96). Compared to those living in households with bottled, piped, or tanker water, children were significantly less likely to receive water in households using well water (OR=0.75; 95% CI: 0.64 to 0.89) or river, spring, or rain water (OR=0.70; 95% CI: 0.53 to 0.92) in the last 24 hours. CONCLUSIONS: About 13 million Indian children aged 6-59 months receive no water. Further research is needed to assess the risks potentially arising from insufficient water, caffeinated beverages, and high sugar drinks at early stages of life.

**57307**

**EUROPEAN TIME TRENDS IN SELF-PERCEIVED WEIGHT: RESULTS FROM HBSC STUDY 2002–2010**

*Kristiina Ojala*

*Paola Dalmaso*

*Raili Välimaa*

*Jorma Tynjälä*

*Jari Villberg*

*Lasse Kannas*

University of Jyväskylä, Finland

INTRODUCTION: The negative subjective evaluation of one's body weight appears common among adolescents. The phenomenon is well documented in research literature with some variations in gender, socioeconomic status and ethnic groups. However, little is known about the changes in the prevalence during the 2000's from wide cross-country comparative study perspective. The present study describes temporal changes in self-perceived body weight among 11-15-year-old adolescents across 40 European countries.

METHODS: The data was obtained from the Health Behaviour in School-aged Children (HBSC) study, which included nationally representative, cross-sectional samples of adolescents. Trend analyses involved data from the surveys conducted in 2002, 2006 and 2010. Adolescents indicated on an international standard questionnaire how they perceive their own body. Answers of the 5 given options were compressed in 3 categories: thin, about right size, fat. Results over time were stratified by country, age and gender. Association with weight status according to IOTF categories was analysed by multivariate multinomial or ordinary logistic regression models, as appropriate. Statistical analyses were carried out using Stata procedures for Complex Survey design.

RESULTS: HBSC trends did not show considerable changes in self-perceived weight in the 2000's. There was a strong positive association between body discontent and non-normal BMI. The gender discrepancy in the self-perception of body weight was remarkable across the countries, as girls reported more often their discontent than boys. This gender difference applied to adolescents with both normal and overweight status.

CONCLUSIONS: It appears that the increased prevalence of obesity has not greatly influenced the criteria of an ideal body type among European adolescents, whereas it seems that the criteria in question has unified across Europe.

**56941**

**“IT HELPS TO UNDERSTAND EATING NUMERICALLY”. THE PRACTICE OF DIETING WITH AN ONLINE SLIMMING SERVICE**

*Mari Niva<sup>1</sup>*

*Johanna Mäkelä<sup>2</sup>*

<sup>1</sup> National Consumer Research Centre, Finland

<sup>2</sup> University of Helsinki, Finland

INTRODUCTION: The past few decades have witnessed an increasing concern for overweight and a proliferation of guides, support groups and personal trainers, and recently, slimming services in the Internet. In Finland, commercial online slimming services offer dieting advice based on personal profiles, food diaries, expert articles, recipes and discussion forums. Inspired by practice theory, this paper analyses what kind of a social practice of slimming the services produce, how the services transform the slimming careers of their users and how the users negotiate the ‘doability’ of online slimming in everyday life.

**METHODS:** The paper is based on an analysis of the Internet sites of two slimming services and personal interviews with 20 users. The interviewees were 21–66-year-old, relatively well-educated women with weight-loss targets between 4 and 40 kg.

**RESULTS:** The findings suggest that slimming with an online service is overridingly characterized by a regular use of a food diary. With its immediate feedback on energy intake and nutrition, the diary acts as a technique of self-control and a device which helps in learning the skill of slimming, and managing weight ‘sensibly’ without crash diets.

**CONCLUSIONS:** The informants shared a vision of being able to stop slimming by ‘internalising normal eating’. While providing expert and peer support, the services promote an individualised practice of losing weight, in which food, nutrition and the body are delineated as measurable and quantifiable objects. The conjunctions of social relations, rhythms and practices of everyday life with the calculative weight-loss practice create tensions which are not always easily reconcilable.

## **Session 8F: METHODS**

**Chair:** Tommi Härkänen, National Institute for Health and Welfare (THL), Finland

**57152**

### **ASSIGNING THE EDUCATION OF ONE SPOUSE TO THE OTHER WHEN ANALYZING HEALTH INSURANCE DATA**

*Denise Muschnik*

*Jelena Jaunzeme*

*Siegfried Geyer*

Medical Sociology Unit, Hannover Medical School, Germany

**INTRODUCTION:** In many epidemiological studies the social status of one person is assigned to their spouse, which is methodologically debatable. When analyzing statutory health insurance data, the question is raised whether the educational information, which is only available for one spouse, can be assigned to the other. The present study comparatively investigates the effect of such an imputation using the example of type 2 diabetes prevalence.

**METHOD:** We use statutory health insurance data from Lower Saxony, Germany, with medical/outpatient information (N=1,987,707) for 2011. First, prevalence rates of type 2 diabetes – stratified by age and sex – are examined depending on the level of education. The educational information is available for approximately 800,000 mainly insured persons in employment. Second, the educational information of a mainly insured person is assigned to their co-insured spouse as an indicator of social status. The aforementioned analyses are then performed for the latter group of approximately 130,000 individuals. Persons aged 18 to 60 are included in the analyses.

**RESULTS:** Type 2 diabetes prevalence rates decline with increasing education in both groups. The co-insured individuals with the assigned educational information show systematically higher prevalence rates.

**DISCUSSIONS:** The declining prevalence rates with higher levels of education in both groups support the assignment of educational information as indicator for social status. Nevertheless, the higher rates of the co-insured spouses might be due to a context effect. Before implementing such a procedure it is recommended to look for striking differences.

**59133**

### **MODELING POINT DATA: SELF-RATED HEALTH AND THE EXPERIENCE OF UNSAFETY IN HELSINKI AS CASE EXAMPLES**

*Teemu Kemppainen*

University of Helsinki, Finland

**INTRODUCTION:** Location is too often treated superficially in the social scientific research on health and well-being. As a consequence, regression models may suffer from spatially correlated residuals, implying poor specification. Furthermore, the substantive advantage that spatial analysis yields is not utilised. Taking location seriously avoids these shortcomings, as this study will show using survey data on self-rated health (SRH) and the experience of unsafety (EoU) as examples. The key aim of the study is to introduce spatial econometric models using a practically oriented and non-mathematical mode of presentation.

**METHOD:** SRH and EoU will be modelled using three different approaches: the results of standard OLS-regression models, design-based regression models and basic spatial econometric models.

**RESULTS:** The spatial component in SRH is lesser than in EoU, which makes intuitively sense, because unsafety is more closely connected to the characteristics of the residential area than health: according to earlier research concerning Helsinki, e.g. low SES of the area is a strong predictor of unsafety. Model diagnostics tell this by means of the spatial structure of the residuals. In the case of EoU, residuals of the final model remain spatially correlated according to the Moran's I statistic for residuals, which calls for a solution. Spatial lag and error models, familiar from the spatial econometric literature, solve this problem but imply different interpretations.

**CONCLUSIONS:** It is important to take location seriously as this enhances our models from a technical point of view. It also sheds more light on the phenomena under study, as we have shown for SRH and EoU by means of spatial econometric models.

**59239**

### **CORRECTING THE EFFECTS OF NON-RESPONSE IN THE REIMBURSED MEDICATION ESTIMATES IN THE ATH SURVEY**

*Tommi Härkänen*

*Risto Kaikkonen*

*Esa Virtala*

*Seppo Koskinen*

National Institute for Health and Welfare (THL), Finland

**OBJECTIVES:** To assess the nonresponse rates in a questionnaire survey with respect to administrative register data, and to correct the bias statistically.

**STUDY DESIGN AND METHODS:** The Regional Health and Welfare Survey in Finland (ATH) in 2010 was based on a national and several regional samples. Missing data analysis was based on socio-demographic register data covering the whole sample. Inverse probability weighting (IPW) and doubly robust (DR) methods were estimated using the logistic regression model, which was selected using the Bayesian information criteria. The crude, weighted and true self-reported turnout in the 2008 municipal election and prevalences of entitlements to specially reimbursed medication were compared.

**RESULTS:** The IPW method appeared to remove a relatively large proportion of the bias compared to the crude prevalence estimates of the turnout and the entitlements to specially reimbursed medication. Several demographic factors were shown to associate with missing data, but few interactions were found.

**CONCLUSIONS:** Our results suggest that the IPW method can improve the accuracy of results of a population survey, and the model selection provides insight into the structure of missing data. Health-related missing data mechanisms are, however, beyond the statistical methods, which mainly rely on socio-demographic information to correct the results.

**57231**

### **THE EFFECT OF CHANGES IN HOUSEHOLD INCOME ON SICKNESS ALLOWANCE DAYS – RANDOM-INTERCEPT MODELS**

*Akseli Aittomäki*

*Pekka Martikainen*

*Lasse Tarkiainen*

*Ossi Rahkonen*

*Eero Lahelma*

Department of Public Health, Hjelt Institute, University of Helsinki, Finland

Population Research Unit, Department of Social Research, University of Helsinki, Finland

**INTRODUCTION:** Earlier discussion on the income-health relationship points to a need to test whether within-person variation of income across time has an effect on health outcomes. Applying such methods, however, raise the issue of potential time lag between economic exposures and health outcomes.

**METHODS:** The data are from an 11-per-cent random sample of the Finnish population, between 25 to 62 years old, followed for hospital treatment as well as sickness allowance days compensated in each calendar year between 1999 and 2007. We estimated the effects of within-person income changes, while adjusting for changes in labour market conditions and prior sickness benefits between 1987 and 2006.

**RESULTS:** The associations between income and sickness allowance varied by the time lag: increasing income was consistently associated with lower probability of sickness allowance after 7 to 9-year time lag. In contrast, the association between income and hospital treatment was roughly similar for all time lags, the effect mainly concentrating in the lowest incomes. In comparison to associations found comparing persons, however, the within-person effects were weaker.

**CONCLUSIONS:** The data suggested that income changes may relate somewhat differently to different health outcomes, and that the time lag between exposure to economic conditions and observed health effects may sometimes be relatively long. We found support for the causal relevance of household income in working age, albeit this mechanism is likely to account for only a part of income-related health-inequality.



## **POSTER SESSION**

### **FRIDAY 29 August at 14.00 - 15.00**

**Chairs: TBC**

**59430**

#### **HEALTH IMPACT ASSESSMENTS OF GOVERNMENT BILLS ON TAXATION**

*Miisa Alestalo*

School of Health Sciences, University of Tampere, Finland

**INTRODUCTION:** Socioeconomic inequalities in health have been large in Finland and the diminution of these inequalities has been one of the main targets of Finnish health policy for decades. Health impact assessment (HIA) in the process of drafting laws is one of the means to identify the often unintended health impacts and their distribution, and a binding norm in Finland. Despite the health policy target, the health gap between socioeconomic groups has persisted, and, even seems to be growing. The aim was to study the implementation of health policy on reducing inequalities in health by means of HIA of government bills concerning taxation of the term of office years 2007–2010, 141 bills in total.

**METHOD:** The material was analysed by content analysis.

**RESULTS:** Health impacts had been recognised and assessed in 7 of the 141 bills. The distribution of the impacts between socioeconomic groups had been identified in 5 of the 7 bills and assessed in 2. Health impacts had been assessed only in bills concerning lifestyle factors like tobacco and alcohol consumption but not in bills concerning the structural determinants of health like income distribution or employment.

**CONCLUSIONS:** The results implicated that the implementation of health policy on reducing socioeconomic inequalities in health has been weak in this part. Health impacts and their distribution cannot be taken into account in decision-making if the information an HIA would have provided is not available.

**57222**

#### **PERCEPTIONS OF CHRONIC DISEASE PATIENTS ABOUT MEDICINE PRICES IN TIMES OF AUSTERITY**

*Jessica Fraeyman (presenter: Sibyl Anthierens)*

*Linda Symons*

*Hans De Loof*

*Guido De Meyer*

*Roy Remmen*

*Philippe Beutels*

*Guido Van Hal*

Research group of Medical Sociology and Health Policy, University of Antwerpen, Belgium

**INTRODUCTION:** Under increasing pressure to contain health expenditures governments across Europe have implemented policies to increase feelings of responsibility in patients regarding rational medicine use, e.g. by increasing co-insurance. The general practitioner (GP) is often unaware of the price patients pay for their medication. In times of austerity, how do chronic disease patients perceive the medicine price they have to pay?

**METHOD:** We used a mixed methods research design. First, we distributed a close-ended questionnaire among 983 chronic disease patients in 30 geographically dispersed Flemish pharmacies. We surveyed for knowledge on the prescription medicine they bought, as well as for their needs for information and their therapeutic compliance. Second, we performed semi-structured interviews with 15 of these patients. We used a constructivist grounded theory approach to help explain the social patterns in chronic medication use.

**RESULTS:** In the quantitative survey, the response rate was 48% (n=473). In the qualitative study, we strived for variety in sampling according to age, income and employment. About a quarter of patients (28%) had no need for information on medicine prices during GP consultations. Patients seem to constantly weigh up the costs and benefits of their medicine use. In this process medicine price is considered to be a burden, but equally so are stigma, impediments to freedom and the practicalities of medicine intake itself. Considering all this, patients strive for optimal health at the cost they are willing to pay.

CONCLUSIONS: In conclusion, regarding patients with chronic disease the general practitioner may also discuss the (perceived) cost that patients face for their medication use. This may improve compliance. Increasing rational medicine use is clearly a matter of shared responsibility.

**57030**

**TELEMEDICINE AS AN EXAMPLE OF THE TRANSNATIONAL SHARING OF ‘COMMON GOOD’ WELFARE: THE JIMUEL PROJECT**

*Julie Bicocchi*

Università di Pisa, Italy

The reflection on the future of European welfare cannot ignore the severe disparities in the access to social and health services between the North and the South of the world. Said disparity has led to a significant migrant influx towards the “European fortress” whose forms of social protection are beginning to fall apart under the weight of an increasing demand that is becoming more and more difficult to meet. But drawing inspiration from the recent recommendations of the European Union in the field of telemedicine (considered best practice for the widespread and efficient promotion of healthcare) it may be possible to put solidarity in next healthcare services: a new model of intervention that could be based, not on the “transfer” of new resources, but on the “sharing” of resources that already exist, such as in the case of Jimuel ([jimuel.org](http://jimuel.org)), a decentralised cooperation project in the health sector mediated by Information Communication Technologies. The study, conducted using an action research approach, shows that considering welfare as a common good to be protected means operating transnationally and avoiding the errors (and naivety) of the first three decades of international cooperation. Jimuel’s telematic clinics, created in southern countries and connected via VOIP technologies to recipient clinics in Italy, allow volunteer doctors to quickly provide general medicine tele-consults, subsequently returning a diagnosis thanks to the mediation of local volunteers. And, thanks to the participation of the Municipality of Pontedera, the project can rely on the support of the immigrant communities in Italy in order to identify new interlocutors in target countries for intervention.

**57193**

**DISCHARGEMANAGEMENT: BARRIERS AND ROLE OF NURSES AND MIDWIVES FOR ETHNICALLY AND SOCIALECONOMICAL DEPRIVED**

*Ann Claeys*

Erasmus University College, Brussels, Belgium

Within the context of a shortened hospital stay, the correct use of the 1st & 2nd line health care & the need for collaboration between services raise a lot of questions about the “integration” of the care and the patients’ care trajectory. Up to now very little is known about the specific needs of deprived patients in their care trajectory, and more in particular during the discharge process. Does discharge needs to be organized differently for different patient groups? The study identifies the characteristics of effective discharge management (DM), analyses the contents and organization of DM and inventarizes the patients’ experiences and needs of DM. We want to know if discharge management is organized differently for ethnically and socio-economically deprived patient groups, and what the role of the nurse and the midwife is in the discharge process. As the focus of the research lies on multicultural society in a metropolitan region, the view of nurses & midwives on the patient is enlarged to the “multicultural patient in a metropolitan region”. In this study mixed methods are used, combining quantitative research (using data on patient trajectories) and qualitative research (using participant-observations, documents and interviews both from health professionals and patients). Discharge is organized multidisciplinary. No discipline claims the coordination of the discharge, it is organised different for specific patient groups, due to language and culture. Ethnically and socio-economic deprived patient groups receive less information. The organisation of discharge is different in each unit. There is no clear coordination role of managing the discharge. A lot of gaps are remaining to be able to pursue an effective discharge policy. There need to be more attention to discharge, specifically to the preparation and communication of discharge, in particular for specific patient groups. A protocol is needed to practitioners.

54662

**PHYSICAL ACTIVITY COUNSELING FOR CARDIOVASCULAR DISEASE PREVENTION: A NATIONWIDE SURVEY AMONG PRIMARY CARE PHYSICIANS**

*Katharina Diehl*<sup>1</sup>

*Tatiana Görig*<sup>1</sup>

*Raphael M. Herr*<sup>1</sup>

*Christina Bock*<sup>1</sup>

*Manfred Mayer*<sup>2, 3</sup>

*Sven Schneider*<sup>1</sup>

<sup>1</sup> Mannheim Institute of Public Health, Social and Preventive Medicine, Medical Faculty Mannheim, Heidelberg University, Germany

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**INTRODUCTION:** Physical inactivity is linked with a greater risk for developing cardiovascular disease (CVD). This is why an increase in physical activity (PA) is considered an important preventive measure. For this reason, the present Germany-wide study investigated if primary care physicians (PCPs) offer PA recommendations in their daily practice. Furthermore, we assessed the attitude towards CVD prevention, the self-rated competence, measures used during routine practice to prevent CVD, and the perceived success of preventive measures.

**METHOD:** Within the scope of the nationwide representative ÄSP-kardio Study, funded by the German Research Foundation (SCHN727/3-1), we collected data from 4,074 German PCPs (response rate: 33.9%). The questionnaire was pretested in a regional pilot study and in cognitive interviews.

**RESULTS:** The majority of PCPs (77.7%) classified an increase of PA for the prevention of CVD as very important. One third (31.2%) considered themselves to be highly competent but less than half of the PCPs (47.7%) said that they were successful in motivating their patients to adapt to such a lifestyle. As a matter of fact, 81.3% recommended an increase of PA to at least half of their patients with low levels of PA. Additionally, we revealed that the individual characteristics of the PCP, the structure of the patient base as well as the properties of the practice play an important role in the prevention of CVD through increased PA.

**CONCLUSIONS:** The majority of PCPs showed positive attitudes towards PA counseling, but reported a lack of competence and success. We suggest qualification measures and reimbursement for counseling services by compulsory health insurances.

56591

**SUNBED USE IN MINORS DESPITE A LEGAL BAN: RESULTS FROM THE SUN-STUDY 2012**

*Katharina Diehl*<sup>1</sup>

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**INTRODUCTION:** Tanned skin is often considered attractive and healthy. Therefore, many Germans expose themselves to artificial UV radiation from sunbeds. However, due to the potential health risks, sunbeds have been classified as carcinogenic to humans by the IARC. Our aim was to investigate, whether the legal ban on sunbed use by minors, which is in law in Germany since August 2009, is followed. **METHOD:** In the nationwide representative SUN-Study 2012, funded by the German Cancer Aid, a subpopulation of 518 minors (14-17 years) was included. In addition to the prevalence of sunbed use, we assessed the reasons for use and the place of last use. Furthermore, we identified the awareness of the above-mentioned legal ban.

**RESULTS:** Altogether, 8.5% of the minors were ever users of sunbeds; 5.2% had used a sunbed during the past twelve months despite the legal ban. Main reasons for using sunbeds were relaxation (85%) and increase of attractiveness (74%). The majority had used unsupervised sunbeds, mainly in gyms (41%).

Among those minors, who had used unsupervised sunbeds, the existence of the legal ban was less widely known than among those who had used supervised sunbeds in tanning studios.

**CONCLUSIONS:** The results show that the legal ban on sunbed use by minors is often circumvented. Tighter controls on the implementation of the law as well as a prohibition of unsupervised sunbeds could be very useful. However, we also revealed that many minor users were not familiar with the ban. This underlines the need for spreading the knowledge about the existence of the law and the knowledge about the potential health risks of sunbed use.

**56594**

#### **GYNECOLOGISTS' ATTITUDES TOWARDS THE SCREENING OF GESTATIONAL DIABETES RECENTLY INCLUDED IN THE GERMAN MATERNITY DIRECTIVE**

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**INTRODUCTION:** Gestational diabetes mellitus is known to be one of the most frequent complications during pregnancy and constitutes an increased risk for pregnant women and the fetus. In March 2012, a new guideline was included into the German maternity directive saying that every pregnant woman should be offered a glucose challenge test (GCT; 50-gram-screening-test) as part of the prenatal checkups. In the present study, resident gynecologists were offered the possibility to comment on this amendment. The study includes results concerning the conduction of the GCT, potential difficulties, and suggestions for improvement.

**METHOD:** Overall, 17 resident gynecologists were interviewed face-to-face (mean length: 33:12 minutes). The semi-structured interviews were transcribed and analyzed using qualitative content analysis following Mayring. The study is funded by the "Nachwuchsakademie Baden-Württemberg".

**RESULTS:** The majority of the gynecologists was glad about the introduction of the screening into the maternity directives as they considered this to be a "long overdue" need [Gyn4]. However, some gynecologists felt that this amendment is not strong enough. They would prefer an oral glucose tolerance test (OGTT, 75-gram-test) which is, according to them, "much more reliable" [Gyn3]. But there were also some gynecologists who thought that the OGTT would strain pregnant women too much and thus deemed it unsuitable for a screening. The gynecologists also named difficulties concerning the implementation of the test, such as for example the delayed introduction of billing codes.

**CONCLUSIONS:** The results provide a first overview of how gynecologists evaluate the inclusion of the GCT into the maternity directives. The results may serve as a basis for larger, possibly quantitative studies on this important public health measure.

**56987**

#### **GOVERNANCE INTO ITALIAN HEALTH CARE SYSTEM: INSUFFICIENCY OF CITIZENS' PARTICIPATION OR LACK IN ORGANIZATIONAL CULTURE?**

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Italian government implemented international directives on humanization of health services, to let cure structures and medical-assistance actions be safer, painless and accessible. In this way admission policies, information and comfort will support citizens-patients participated assistance plans. Health Care National System would adopt a patient centred perspective to satisfy (both merely medical and social) health needs, using organization participation and change process to enact health policies. The Italian Law Decree n.150/2009, article 3, declares "performance measurement and evaluation aim for improve Public Administration's services quality", so Health Ministry aims at a multidimensional evaluative perspective to join patient orientation, process management, organization development and economic-financial objectives

through governance in health care system and all its units. Like Mengozzi says, citizens address to public health system cause it is scientifically and technically advanced, but not organizationally and politically. People ask health care system a “responsiveness-réactivité”, that is the capability to answer in an integrated way to social and health needs. WHO in 2000 affirmed that if citizens’ expectations are satisfied, it can reach a higher general health level, cause patients are more satisfied if they know they are treated in a good way. However, Italian official guide lines for quality of health care performance are not yet declared, so there are not yet official tools to define and facilitate governance process. So it is possible to observe that health care workers complain an insufficient citizens-patients interest into participation for health care system’s improvement. But on the other side citizens denounce a lack into organizational culture, that is sanitary system’s units are not linked by a unique organizational culture, so citizens intervention is useless because it is unapplied out of the single health care unit.

**55026**

## **UNEMPLOYMENT, SOCIAL JUSTICE AND HEALTH**

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**INTRODUCTION:** Although socially disadvantaged groups are known to have a high risk of poor health the involved mechanisms and psychosocial dynamics are not fully understood. Long-term unemployment and the perception of social justice may both additionally endanger health. We therefore set out to explore the specific impact of these two context variables on self-reported health, health behaviour, and resources in marginalised groups.

**METHODS:** A structured interview survey was conducted in three federal provinces in Austria, which targeted a quota sample of 486 subjects in long-term unemployment.

**RESULTS:** Both, duration of long-term unemployment and low perceived social justice, are strongly associated with self-reported poor health and low personal (internal) and social (external) health resources. The best differentiation of dependent variables concerning the univariate analyses was found with respect to social health resources, as all variables on this level significantly correlated with perceived social justice but not with duration of long-term unemployment.

**CONCLUSION:** While this study does not allow to establish causal relationships, the associations we found suggest that also perceived social justice needs to be taken into account in interventions that are intended to foster equity in health among socially disadvantaged groups.

**55679**

## **MEASURING SUBJECTIVE SOCIAL STATUS IN SOCIAL EPIDEMIOLOGY: CONSTRUCT VALIDITY OF THE MACARTHUR SCALE**

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*Cornelia Lange*

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**INTRODUCTION:** The MacArthur Scale has become a standard instrument for measuring subjective social status (SSS) in social epidemiology. We used this instrument in a pilot study and investigated its construct validity and whether SSS is associated with health over and above objective socioeconomic status (SES).

**METHODS:** Data were obtained from a cross-sectional survey among adults (n=1,571, age=18+ years) carried out within the 'German Health Update' (GEDA) study. SSS was measured with a German version of the MacArthur Scale. Convergent and discriminant validity were examined using correlation and factor analysis. Associations between SSS and health were estimated using logistic regression models adjusted for age and objective SES measures (education, occupation, income).

**RESULTS:** The strongest correlations to SSS were found with measures of similar constructs such as a multidimensional SES-index, income, occupational status, educational level, and self-perceived living standard (r range: 0.32–0.60; p<0.001). Weaker correlations were found between SSS and measures of dissimilar constructs such as social support, well-being, depressiveness, and body-mass-index in men and women, respectively (r range: -0.29–0.30; p<0.001). Factor analysis did not show considerable loadings of



SSS either on well-being or depressiveness. After adjusting for age and objective SES measures, lower SSS was independently associated with higher odds of adverse health outcomes.

**CONCLUSIONS:** These findings provide support for the convergent and discriminant validity of the MacArthur Scale and indicate that self-perceptions of social disadvantage may have important health implications beyond the impact of objective SES. Future studies should investigate the mechanisms underlying the relationship between SSS and health.

**57375**

### **HEALTH PROMOTION OF STAFF IN LONG TERM CARE - PROBE IN THE CZECH REPUBLIC**

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**INTRODUCTION:** Population aging has economic, political and social consequences. Planning needs of long term care (LTC), including increasing the number of informal and professional caregivers, responds to the demographic changes. Although family caregivers dominate in many OECD countries including the Czech Republic, a number of professionals will double until 2050 (even triple in the Czech Republic). The need for quality institutions providing LTC setting is linked with good working conditions and health promotion of their employees.

**METHODS:** Within the reflection of the current state of health promotion and working conditions of formal caregivers in the Czech environment, we conducted a qualitative probe (focus groups, N = 29). The objective was to determine the subjective opinions of this target group to employers' efforts to promote their health by improving the working conditions. Discussions were held in five Czech institutions providing LTC, with different forms of financing (hospital wards, home care services, home with special regime) in 2013. The key themes included the level of workplace health promotion and related positive and negative factors affecting work performance.

**RESULTS:** In accordance with international studies, we found that formal carers perceive some identical positive and negative factors in their profession, regardless of the type of LTC institution. The key negative factors are social and financial underestimation, lack of time on a more individual approach to clients/patients or bloated administration. The positive aspects include clients'/patients' satisfaction, improvement of their health, good team or meaningful work.

**DISCUSSION:** Monitoring the level of working conditions, health promotion and supervision belongs to the underrated areas in LTC in the Czech Republic. Prevention and health promotion of the aging population and of formal and informal caregivers is an important strategic tool in LTC policy.

**55355**

### **ARE OVERWEIGHT AND OBESITY RELATED TO POOR SELF-RATED HEALTH AMONG ADOLESCENTS IN GERMANY?**

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**INTRODUCTION:** International studies show that overweight and obese boys and girls report more often poor self-rated health (SRH) compared to normal weight peers. This study analyses the relation between overweight/obesity and SRH among adolescents in Germany.

**METHODS:** Data stem from the German Health Interview and Examination Survey for Children and Adolescents (KiGGS, baseline 2003-2006). For the definition of overweight and obesity, body mass index (BMI) was calculated based on standardised height and weight measurements. SRH of 6,813 adolescents aged 11 to 17 years was raised with the question: "How would you describe your health in general?" (Response categories: "very good, good, fair, poor and very poor"). We collapse these categories into a binary outcome in which poor health represents fair, poor and very poor SRH. The relation between BMI and SRH was calculated using binary logistic regression models adjusted for age.

**RESULTS:** Overweight and obese boys report more often poor SRH compared to normal weight peers (overweight boys: OR 1.99; 95 % CI 1.36-2.89; obese boys: OR 2.68; 95 % CI 1.85-3.89). In girls, there is only a relation between obesity and SRH: Compared to normal weight peers, obese girls have a 3.0-fold increased risk of poor SRH (OR 3.23; 95 % CI 2.32-4.49).

**CONCLUSIONS:** Overweight and especially obesity are related to poor SRH among adolescents in Germany. The findings highlight the importance of prevention measures against obesity at a young age. In addition, measures are needed to improve the health-related quality of life of overweight and obese adolescents.

**57965**

**SOCIOECONOMIC DIFFERENCES IN SMOKING, PHYSICAL INACTIVITY AND OBESITY AMONG 18-79 YEARS ADULTS IN GERMANY**

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**INTRODUCTION:** We analyzed socioeconomic differences in smoking, physical inactivity, and obesity among men and women aged 18 to 79 years in Germany.

**METHODS:** We used data from the “German Health Interview and Examination Survey for Adults” (DEGS1) which the Robert Koch Institute conducted in the period from 2008 to 2011 (n=8152). Information on smoking and physical inactivity was obtained via health interviews. Obesity was assessed using measurements of body height and weight (body mass index, BMI). Socioeconomic status is derived from a multidimensional index which includes information on education attainment, occupational status and household income.

**RESULTS:** Men with low socioeconomic status were found to be more likely to smoke (OR=2.97, 95% CI=2.20-4.01), to be physically inactive (OR=4.89, 95% CI=3.67-6.51), and to be obese (OR=2.33, 95% CI=1.66-3.25) than men with high socioeconomic status. For women, socioeconomic status had a similar effect on smoking and physical inactivity as it did in men (OR = 2.29, 95% CI=1.68-3.11 and OR = 3.99, 95% CI = 2.94-5.41, respectively), while its effect on obesity was even greater than in men (OR = 4.39, 95%CI = 3.15–6.12).

**CONCLUSIONS:** These results imply that persons of low socioeconomic status should continued to be an important target group for preventive and health-promoting measures, both in health policy and in medical practice.

**57227**

**OCCUPATIONAL CLASS INEQUALITIES IN SICKNESS ABSENCE AFTER HOSPITALIZATION**

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**INTRODUCTION:** Occupational class is associated with ill-health and its consequences. We examined whether the occupational classes face different consequences of ill-health measured by sickness absence after hospitalization.

**METHODS:** 69968 persons with hospitalizations were identified among the City of Helsinki personnel using national hospitalization register, and followed up from 1996 to 2009 on national sickness absence register. Monthly age adjusted average sickness absence days and 95 % confidence intervals from 12 months before to 12 months after hospitalizations due to cardiovascular diseases, mental disorders, musculoskeletal diseases, malignant neoplasms and any cause were calculated across four hierarchical occupational classes.

**RESULTS:** Sickness absence was more common among the lower occupational classes before hospitalization in all diagnostic groups except mental disorders. Sickness absence increased after hospitalization in all occupational classes, and decreased at different rates depending on occupational class and hospitalization diagnosis. Six months after hospitalization due to cardiovascular disease the lowest occupational class had on average 2.9 (CI 2.5 to 3.3) sickness absence days per month, while the highest occupational class had 1.2 days (CI 0.8 to 1.5). Similar occupational class differences were observed after

hospitalizations due to musculoskeletal disorders or any cause, but not due to mental disorders or malignant neoplasms.

CONCLUSIONS: After hospitalization sickness absence rates may remain elevated longer in lower occupational classes compared to the higher occupational classes. This may indicate occupational class differences in receiving care, requirements of work, or condition severity.

**59229**

### **STIGMA EXPERIENCE OF THALASSEMIA PATIENTS IN CYPRUS**

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Since 1972 Cyprus managed to control the birth of children with Thalassemia through screening programmes and awareness-raising campaigns in collaboration with the Church of Cyprus. Currently modern generation medication manages to eliminate the external appearance effect of Thalassemia that constituted the major cause of the social stigmatization of patients, which is still the case for the middle aged persons living with Thalassemia. Stigma in the past was also reinforced by the death of patients in young ages. Through In-depth interviews with 10 persons living with Thalassemia and with their spouses, stigma was explored within the context of a qualitative study of these patients' experience of living with Thalassemia and the impact of the disease on the person's and on the family's everyday life. The patients were selected from the registry of the Cyprus Thalassemia Organisation, the interviews were audio recorded, transcribed and analysed through Atlas Ti software. This qualitative research is part of a larger study which explores the quality of life of patients with Thalassemia in Cyprus and is co-funded by the Republic of Cyprus and the European Regional Development Fund. The study has been approved by the Cyprus National Bioethics Committee.

**57126**

### **REGIONAL AND CITY-LEVEL HEALTH AND WELLBEING DIFFERENCES IN FINLAND 2013**

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INTRODUCTION: One of the basic tasks in municipalities in Finland is the promotion of health and well-being of residents but the information needed is lacking. Precise information on residents' health and well-being makes it easier to plan services in the area and evaluate the influence of health promotion actions. The Regional Health and Well-being Study (ATH, from its Finnish initials) provides municipalities and municipal federations monitoring system of health and well-being together with the factors affecting them. METHOD: The Regional Health and Well-being Survey were conducted by questionnaire survey in 2013 with sample of 57 000 Finns (response-rate 54 %). The ATH-study covers up to 150 000 sample of Finns during the period 2013–2014. Furthermore, the research is extended to cover ethnic groups (the UTH-

study). Information on residents' well-being, health and functional capacity will be reported immediately to experts with graphs, inter-actual and brief reports.

**RESULTS:** Regional, area- and municipal-level differences in Finland were found in various indicators concerning ex. the limited work ability (WAI, single-item), Espoo 17% vs. Turku 27%. Moreover significant differences were found in quality of life, participation in society, trust ex. municipal decisions, unmet needs ex. cultural services, various health indicators ex. self-rated health, functional capacity, health behavior and risk factors ex. smoking, obesity, and use of service. Local authorities have adopted their results for decision making.

**CONCLUSIONS:** The ATH-study helps municipalities to cope with the statutory obligation to monitor residents' health and factors that affect it, by population groups and the ATH-study is nationally and internationally valuable and comparable data.

**56018**

#### **OBESITY AND WORK ABILITY IN MIDLIFE: A PROSPECTIVE COHORT STUDY**

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The study was funded by the Finnish Work Environment Fund (111252).

**INTRODUCTION:** There is little evidence concerning the longitudinal associations between obesity, weight change and work ability (WA) between early and middle adulthood. We investigated the effect of obesity at 31 years and weight change between 31 and 46 years on WA at 46.

**PARTICIPANTS AND METHODS:** The study population included employed 46-year-old men and women (n~3000), born in Northern Finland in 1966. Data on their current perceived WA compared to lifetime best (scale 0 to 10; first item of Work Ability Index) was assessed through questionnaires at the age of 46. Weight (kg) and height (cm) were measured at 31 years. At the age of 46, weight and height were self-reported. Analyses of covariance were used to investigate the effect of BMI class [normal weight (BMI <25.0kg/m<sup>2</sup>), overweight (BMI 25.0-29.9) and obese (BMI ≥30.0)] on WA at 46. Weight change between 31 and 46 years was classified into four groups (≤15th, 15th-50th, 50th-85th and >85th percentile). Basic education, physical strenuousness of work, sedentary work, job stress, parity, and BMI at the age of 14 or 31 were controlled for in the analyses.

**RESULTS:** Nearly all participants gained weight between the age of 31 and 46. Among men, overweight and obesity at 31, and among women, obesity at 31 predicted decreased WA at 46. Weight gain (>85 percentile) significantly decreased WA among both genders.

**CONCLUSIONS:** Obesity and weight gain increase the risk of deteriorated work ability in midlife.

57178

**LIFETIME HEALTH BEHAVIORS AND WORK ABILITY IN MIDLIFE: A PROSPECTIVE COHORT STUDY**

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The study was funded by the Finnish Work Environment Fund (111252).

**INTRODUCTION:** Very little evidence exists of the cumulative and longitudinal effects of health behaviors on work ability (WA). We investigated the cumulative effects of lifetime (14–46y) health behaviors on WA at the age of 46.

**METHODS:** The study population included employed 46-year-old men and women (n~2800), born in Northern Finland in 1966. Data on their current perceived WA compared to lifetime best (scale 0 to 10; first item of Work Ability Index), and health behaviors (leisure time physical activity, smoking and alcohol consumption) were assessed through questionnaires. Health trajectories were created on the basis of health behaviors at the ages of 14, 31 and 46. Stress-related eating at the age of 31 was also assessed. Analysis of covariance was used to investigate the effects of health trajectories and stress-related eating and drinking on WA at 46. The analyses were controlled for basic education, physical strenuousness of work, sedentary work, job stress, and BMI at the age of 31.

**RESULTS:** Four health trajectories were created; always healthy, change from healthy to average health, change from healthy to unhealthy, and always unhealthy. Those who belonged to the healthy to unhealthy and always unhealthy trajectories had lower levels of WA compared to those with the always healthy trajectory, among both genders. After adjusting for covariates, stress-related eating and drinking had no effect on WA.

**CONCLUSIONS:** Lifetime unhealthy behaviors increase the risk of poorer WA in midlife.

59435

**SOCIAL REPRESENTATIONS OF CANCER IN 9 TO 12 YEARS OLD CHILDREN: A QUALITATIVE STUDY**

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**CONTEXT:** Social inequalities for cancer mortality are observed in all European countries and are particularly pronounced in France. According to National cancer plans, the role of school should be strengthened to fight against these inequalities. Building interventions for cancer prevention at school requires a good knowledge of social representations which influence children practices and of social differentiations.

**GOAL:** To identify social representations of cancer in 9 to 12 years old children at schools. To assess whether the prevalence of some cancer representations is associated with socioeconomic level of school zones.

**METHOD:** Grade schools 3th to 5th were interviewed using “write and draw” method. Schools were classified advantaged or disadvantaged using the French adaptation of European Deprivation Index. Drawings content was analyzed through items appearance. Items were then grouped into themes and



subthemes. A double analyze was performed followed by a meeting of a multidisciplinary group of experts to seek a consensus.

**RESULTS:** Eight classes (191 students) were interviewed. Students more frequently cited an affected organ (61%), tobacco (38%), death (38%), a definition of cancer as an illness and hair loss (27%). The concept of care / treatment, including hospital, medication, surgery or doctor, was cited by only 23% of children and prevention by only 20% of them. The average number of different items listed per student increased with grade and social level.

**CONCLUSIONS:** This exploratory survey identified social representations of cancer in young children according to social level. This is the first step to establish a validated pedagogical intervention aimed to reduce social inequalities in health.

**56089**

## **HEALTH LITERACY & ACTIVE AGEING EDUCATION**

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**INTRODUCTION:** Literacy is a heavily discussed topic at the moment: media literacy, computer literacy, and last but not least health literacy. If literacy is seen in the direct sense, it is the competence to read texts, to gain relevant information, and to be able to participate in social life as a consequence. The term “health literacy” is used in the sense of health alphabetization, health education and for developing skills for a healthy living. Active ageing is a field in which a lot of information has been collected in recent years, for example on healthy dieting for older people, sports, or health promotion for older people. The WHO (2002) defines Active Ageing as “optimizing opportunities for health”. Health education is one way of optimizing health in old age. In the framework of a European project, 600 older people are asked about their opinion about active ageing education (2014). Then the project will develop an active ageing literacy course in ten modules for seniors 55+ years (2015).

**METHODS:** The main research questions this paper wants to answer are: What is “active ageing education” and how responsive are older people to it? How can active ageing education be integrated into local communities? Two methods are applied to answer these questions: Desk Research – a keyword-led search through scientific databases about active ageing education in Europe. Quantitative Questionnaires – a survey about the main challenges and problems which older people face with active ageing education (600 questionnaires returned).

**RESULTS AND CONCLUSIONS:** Although active ageing has been explored thoroughly across the EU, only a few courses or trainings exist on the community level and are taken into consideration by older people themselves. The results show the need for advisory services in comparison to internet services or platforms on active ageing.

**49177**

## **COMPETENCES FOR DRIVING A CAR IN OLD AGE. RESULTS OF AN INTERVIEW STUDY**

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**INTRODUCTION:** Driving a car requires a set of competences: the ability to see, react quickly, to function cognitively and to be able to assess risks. There are some studies about driving in old age, especially from the United States, and recently from Germany. Studies suggest that driving is influenced by a two-fold set of competences: performance (being able to drive physically and mentally) and personality (strategies of driving, driving style, avoidance strategies etc.).

**METHODS:** The study took place using qualitative semi-structured interviews. 16 people (70-95years) were interviewed alone or in pairs in their own homes in rural and urban areas in Austria. The interviews were taped and transcribed according to methods of empirical research and transcription guidelines. The interview transcripts were analysed using topical analysis.

**RESULTS:** The results suggest that older people are highly secure when driving their cars, no matter if they have health problems or not. The decision to terminate driving is a gradual process for healthy older people on the one hand consisting of terminating night driving, driving in bad weather conditions or long distance journeys first (avoidance strategies) and then finally terminating driving completely. The decision to terminate driving for older people with impairments on the other hand is a punctual decision after illness

or an accident (performance). The meaning of driving the car is high for older people, especially when there are no public transport alternatives.

**CONCLUSIONS:** The subjective views of older people and the views of others participating in traffic differ a lot: older people see themselves as safe drivers while others often have stereotypes of “insecure older drivers”. Qualitative research in this area is rare, more explorative research could be done to deepen insights into decision making processes between partners, gender gaps and finding solutions in reducing stereotypical pictures of older drivers.

**51226**

#### **WORKPLACE INJURIES (WI) - SOCIO-DEMOGRAPHIC, OCCUPATIONAL AND HEALTH RELATED DETERMINANTS**

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*Lars Eric Kroll*

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**INTRODUCTION:** According to the Haddon-Matrix characteristics of the host (e.g. socio-demographics, individual behavior), the agent (energy-transmitting objects) and the environment (e.g. physical, organizational) are the main determinants of unintentional injuries.

**METHODS:** Focusing on host characteristics the present analysis tries to clarify whether health-related determinants and mental work strain contribute to the explanation of WI. The phone survey German Health Update 2010 (n=22,050) provides information on up to three medically treated WI within one year (gainfully employed 18-70ys, n=14,041). Logistic regression considering socio-demographic (e.g. gender, age), occupational (profession, work strains) and health-related determinants (chronic conditions, behavior) is applied to identify relevant risk factors.

**RESULTS AND CONCLUSIONS:** Overall, 2.8% (CI95 2.4-3.2) of persons gainfully employed reported at least one WI (women: 0.9% CI95 0.7-1.2; men: 4.3% CI95 3.7-5.0). In the final model, male sex (OR 3.2), age 18-29 (OR 1.5) as well as agricultural (OR 5.6), technical (OR 3.4), skilled service (OR 4.2) or manual (OR 5.2) and unskilled service (OR 3.3) or manual (OR 5.1) profession is associated with a significantly higher probability of WI. The same holds for work strain such as heavy carrying (OR 1.7), frequent squatting/stooping etc. (OR 1.5), a physically demanding work place setting (e.g. noise, heat, emissions) (OR 1.5) and working under pressure (OR 1.4). Among the health-related variables lack of physical activity (OR 1.5) and obesity (OR 1.8) entail significantly higher WI probabilities. Increased ORs for harmful alcohol consumption, regular smoking, chronic back pain, frequently working overtime or doing shift-work decrease and lose significance when models are adjusted for occupations and physical work strain. Certain indicators for health, health behavior and mental work strain increase the probability for WI or are mediated by occupational factors. These aspects should be considered when tailoring measures for the prevention of WI.

**75423**

#### **REGIONAL DIFFERENCES IN HEALTH AND HEALTH BEHAVIOUR AMONG YOUNG ADULTS IN FINLAND**

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**INTRODUCTION:** Upcoming social welfare and health care reform will allocate related services among five powerful regional actors: the proposed Helsinki, Turku, Tampere, Kuopio and Oulu regions. This study examines differences in the health and health behaviour of young adults, both regional and socio-economic, between the proposed regions.

**METHODS:** Regional Health and Well-being Study (ATH) data (2012-2013) includes 4,869 young adults aged 20-34. Analysis methods included cross tabulation and confidence intervals, age standardization and sample weights were applied.

**RESULTS:** The proportion of men estimating their state of health to be moderate or worse was lowest in Tampere (18%) and highest in Turku (30%) even when educational level or financial situation was controlled for. Among women, mental health problems or other conditions diagnosed or treated by a doctor in the preceding 12 months were most common in Kuopio across all educational or financial situation groups, but self-reported depression was most common in Helsinki.

Among women, daily smoking was most common in Oulu and hazardous drinking was most common in Helsinki even when educational level or financial situation was controlled for. Among men, Turku and Oulu featured the highest proportions of daily smokers and hazardous drinkers.

**CONCLUSIONS:** Differences in the health and health behaviour of young adults between the proposed social welfare and health care regions cannot be fully explained by socio-demographic differences. Experiencing financial difficulties appears to be strongly associated with both health problems and risky health behaviour, while lower educational levels appear to have similar but less pronounced effects.

**56786**

### **13 YEAR TRENDS IN SICKNESS ABSENCE AMONG YOUNG MUNICIPAL EMPLOYEES**

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**INTRODUCTION:** Young adults entering employment are a key group for extending work careers. Prolonged sickness absence is a risk for work disability and disability retirement. However, trends in sickness absence among young employees are poorly known. Our aim was to examine trends in sickness absence among young municipal employees.

**METHODS:** Permanently and temporarily employed staff of City of Helsinki in 2000-2012 aged 18-24, 25-29, 30-34 and 35-59 was included. We examined self-certified 1-3 days, and medically certified intermediate 4-14 days and long 14+ days sickness absence spells. Joinpoint Regression Programme was used to identify points in the sickness absence trends, where major changes in the trends occur.

**RESULTS:** Sickness absence spells of any length increased from 2000 to 2012, but in 2008 the trends started to decline. Young employees had more short sickness absence spells than older employees, but intermediate spells were broadly similar among younger and older employees. Older employees had more long sickness absence spells than young employees. Women had more sickness absence spells than men in all age-groups.

**CONCLUSIONS:** All lengths of sickness absence have increased during the study period. Young employees are still in the age with little chronic diseases, so that implies, that there are also other reasons behind increased sickness absence, than employees' state of health. Reducing sickness absence and extending working careers among young employees needs more evidence on trends and changes in sickness absence. Extending work careers requires investments in health and work ability before illnesses occur.

**57176**

### **THE LEVEL OF RELIGIOUSNESS AS A PREDICTOR OF PSYCHOLOGICAL AND SOCIAL WELL-BEING IN OLDER PEOPLE**

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**INTRODUCTION:** Religion not only provides an outlet for social support but also a framework to cope with and reduce/buffer stress. Inclusion of religious engagement as a variable in health research is needed, especially with respect to mental/social well-being. The aim of presented research was to verify hypotheses on the relationship between religiousness and well-being in older age.

**METHODS:** The sample population consisted of 367 randomly selected older Roman Catholics living in Krakow, Poland. Data was collected using a structured questionnaire. Religiosity was measured by assessing the following dimensions: ritualistic, experiential, ideological, consequential and intellectual.

Also religious coping and support were measured. Psychological and social well-being were assessed using SF-20, HADS, DUKE Social Support Scale and Loneliness Scale. In the statistical analyses Hierarchical Cluster Analysis and regression analyses were performed.

**RESULTS:** Multivariate linear regression analysis for mental well-being as a dependent variable showed that better mental health characterized those individuals who reported higher level of religious: practices ( $B=0,24;p<0,05$ ), beliefs ( $B=0,46;p<0,05$ ), experience ( $B=0,37;p<0,05$ ) and coping ( $B=0,19;p<0,05$ ). Similar analyses done for subjective symptoms of depression revealed that less depressed were those who reported higher frequency of religious practices ( $B=-0,31;p<0,05$ ), as well as those who reported stronger faith ( $B=-0,26; p<0,05$ ), deeper religious experiences ( $B=-0,28;p<0,05$ ) and higher level of social support obtained in religious settings ( $B=-0,17;p<0,05$ ). Two clusters were extracted using K-means cluster analysis. Regression analyses showed that individuals from cluster 1 (those who scored higher on each dimension of religiousness) had better mental health and were less depressed than those from cluster 2. Significant relationships were also found between the level of religiousness and social well-being social functioning.

**CONCLUSIONS:** Religiousness is a significant determinant of psychological and social well-being in later life.

## Practical information

Information on travel, accomodation, shopping and sights in Helsinki

- Travel information on Helsinki  
Helsinki City Tourist Information, Pohjoisesplanadi 19, Mon-Fri 9am-8pm, Sat-Sun 9am-6pm.  
<http://www.visithelsinki.fi/en/come/tourist-information/helsinki-tourist-information>
- Emergency  
In the case of emergency, the general emergency number in Finland is 112.
- Electricity  
Electricity sockets take 2 pin round plugs and supply voltage is 220V.
- Time  
The time zone for Finland is EET (2 +GMT)
- Language  
Finnish and Swedish are the two main official languages in Finland. English is very popular and spoken everywhere in Helsinki.
- Weather  
The climate in Helsinki is a sea-climate with temperatures in August between 20-25°C. There is always a chance of showers, due to variable weather patterns. Evenings can be cool so it is advised to bring a jacket or a sweater.
- Currency and Banks  
The currency is EURO (€). Other currencies can be changed at the banks and hotels. Credit cards are generally accepted everywhere. The closest bank and opening hours to the conference site is Nordea Bank, Aleksanterinkatu 30, Weekdays: 10:00–16:30.
- Pharmacy  
The closest pharmacy is Kauppatorin Apteekki and it is located in Pohjoisesplanadi 2. The opening hours are Mon-Thu 8:00–19:00, Fri 08:00–18:00, Sat 9-16:00, and Sun closed.
- Shopping  
The largest shopping malls, such as Sokos and Stockmann, are open on Weekdays 9:00-21:00, Sat 9:00–18:00, Sun 12:00–18:00. The smaller shops are open on Weekdays 10:00–18:00, Sat 10:00-14:00
- To and from Helsinki-Vantaa Airport  
The public bus 615 costs 4.50 € and takes you to the main railway station (located in the heart of Helsinki) in about 45 minutes. Please check further information:  
[www.hsl.fi/en/timetables-and-routes/terminals/airport-connections](http://www.hsl.fi/en/timetables-and-routes/terminals/airport-connections)  
  
The direct Finnair bus costs 6.20 € and takes you to the main railway station in about 25 minutes. Please check further information: [http://media.finnair.com/files/pdf/FINNAIR\\_CITY\\_BUS\\_TIMETABLE.pdf](http://media.finnair.com/files/pdf/FINNAIR_CITY_BUS_TIMETABLE.pdf)